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ABSTRACT

A large and complicated body of law deals primarily with required parental involvement in health care decisions concerning adolescent children. Addressing that body of legislation, Part 1 of this two-part background paper focuses on a survey of laws requiring parental consent to health services for minors or parental notification of a minor's decision to obtain health services or receipt of health services. Part 1 furnishes an overview of laws allocating authority for adolescent health care decision making among adolescents, parents, health professionals, and the state. Other topics covered in Part 1 are the legal requirement of parental consent, exceptions to the parental consent requirement, confidentiality and parental notification, and the impact of parental consent and notification requirements. Part 2 reviews empirical studies regarding the competency of minors to make health care decisions and discusses the implications of these studies for the formulation of public policy with respect to the allocation of authority for adolescent health care decision making. Concluding discussion deals with the role of the federal government in public policy formulation and proposes a conceptual framework for policy formation. A total of 116 references are cited. A summary of core studies and ethical standards concerning minors' access to health services are appended. (RH)

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ADOLESCENT HEALTH CARE DECISION MAKING: THE LAW AND PUBLIC POLICY

Josephine Gittler, Mary Quigley-Rick,
and Michael J. Saks

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INTRODUCTION

This background paper on law and public policy concerning adolescent health care decision making was prepared for the United States Congress Office of Technology Assessment's Adolescent Health Care Project under contract to the Carnegie Council on Adolescent Development. Adolescent health services have been defined by the Office of Technology Assessment for purposes of this background paper as follows:

> Adolescent health services are provided to 10 to 18-year olds by physicians, mental health professionals, nurse practitioners, clinical social workers, and others in private physician offices, emergency rooms, family planning clinics, community health and mental health centers, school-based clinics, substance abuse treatment programs, hospitals, mental health institutions, and other settings.

Who should decide whether an adolescent is provided health services, what health services are provided and how health services are provided? And who should decide whether communications between minors and health professionals and the health care records of minors are to be treated as confidential? The adolescent? The adolescent's parents or legal guardian? Health professionals? The State? Another more concise way of stating these questions is to ask how the law should allocate authority for health care decision making among these different actors.

These questions are addressed in a body of law that deals primarily with the nature and extent of required parental involvement in health care decisions with respect to adolescents. This body of law determines whether parents of an adolescent must consent to the delivery of health services to the adolescent, and whether the adolescent's parent must be notified of the adolescent's decision to obtain health services or the adolescent's actual receipt of health services.

This body of law is large and complicated and is not always clear or consistent. It is derived from multiple sources which explains, at least in part, its complexity, lack of clarity, and inconsistency. It is the product of actions of different public policy makers and consists of decisions of courts, statutes passed by legislatures and regulations of executive departments and administrative agencies. It is an outgrowth of decisions, statutes and regulations from a variety of jurisdictions. It has traditionally been a matter for the individual state governments to determine and hence varies from state to state but it is controlled or influenced to some extent by the federal government acting through the federal courts, Congress, and the federal agencies. Moreover, it is an amalgam of principles and rules drawn from different areas of law such as tort law, contract law, family law and constitutional law.

Part One of this background paper furnishes an overview of existing laws allocating authority for adolescent health care decision making among adolescents, their parents, health professionals and the State. The primary focus of this portion of the paper is the survey of laws requiring parental consent to health services for minors or requiring parental notification of a minor's decision to obtain health services or the minor's receipt of health services. Part Two of the paper reviews the empirical studies regarding the competency of minors to make health care decisions and discusses the implications of the findings of these studies for the formulation of public policy with respect to the allocation of authority for adolescent health care decision making. The Conclusion deals with the role of the federal government as opposed to the role of state governments in such public policy formulation and proposes a conceptual framework for public policy formulation.

PART ONE

PARENTAL INVOLVEMENT IN ADOLESCENT HEALTH CARE DECISION MAKING: EXISTING LAWS

SECTION ONE
LEGAL REQUIREMENT OF PARENTAL CONSENT

Historically, the law has drawn a sharp distinction between adults and minors. Under the Anglo-American law it is well established that minors are subject to a variety of disabilities and restrictions on their liberty,[1] and under Anglo-American law, it is also well-established that parents have a right to care, custody and control of their minor children.[2] Therefore, it is not surprising that the common law rule is that consent of a minor's parent is generally required in medical or surgical care of the minor.[3]

The age of majority is the age at which a young person legally attains the status of an adult. Upon attainment of this status, a young person is no longer subject to parental authority or control, and he or she assumes the responsibilities as well as the rights of an adult. The individual states have the authority to set the age of majority. For many years the age of majority in most states was twenty-one years. Almost all states lowered the age of majority to eighteen years with the 1971 ratification of the Twenty-sixth Amendment to the U.S. Constitution permitting persons eighteen years of age to vote in federal elections. Today, the age of majority is eighteen years in forty-seven states[4] and nineteen years in the remaining three states.[5]

States can modify the age of majority so as to confer upon minors rights normally associated with majority. Thus in several states, statutes authorize minors who have reached a designated age, ranging from fourteen years to sixteen years, to consent to health care.[6]

The parental consent requirement reflects principles in tort and contract law governing the provision of health services to adults and the application of these principles to minors. Under the tort law doctrine of informed consent, a physician or surgeon has a duty to give an adult patient the information necessary for making an informed and voluntary choice concerning medical treatment or surgery,[7] and failure on the part of a physician or surgeon to obtain informed consent from a patient may constitute a tort giving rise to a civil liability and an award of damages.[8] In addition, under contract law the relationship between a doctor and an adult patient is usually considered a contractual relationship.[9]

Parental consent has been required for provision of health services to minors because minors traditionally have been deemed incompetent as a matter of law to give the informed consent to medical and surgical care. Minors, likewise, traditionally have been deemed incompetent as a matter of law to enter into binding contracts, and hence they traditionally have had the power to disaffirm contracts, including contracts with physicians and

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surgeons. Underlying the legal rule that minors are incompetent to give consent to medical and surgical care and the legal rule that they are incompetent to enter into binding contracts with physicians and surgeons are assumptions about their lack of decision-making capacity.[10]

Given the fact that the law regards minors as incompetent to consent to health services because of lack of decision-making capacity, it is not surprising that a major rationale for the parental consent requirement is their protection from improvident health care decision making. Accepting for the sake of argument this presumption, there remains the question of why parents have been legally authorized to make health care decisions on behalf of their minor children. There appears to be two operative premises in this regard. One premise is that parents, in contrast to their minor children, possess the intelligence, maturity, and experience needed for adequate and appropriate health care decision making, and the other premise is that parents usually have an identity of interest with their minor children and will act in their best interests.

The parental consent requirement also has been viewed as promoting family autonomy and privacy in general and as promoting parental authority and control of minor children in particular. Family autonomy and parental authority in turn are sometimes viewed as fostering the stability and cohesiveness of the family as an institution and of individual family units. Family autonomy for this purpose refers to non-interference by the state in the right of families to make important decisions concerning family life and family members.[11] A tradition of family autonomy is deeply imbedded in Anglo-American law and can be traced back to Roman law, the Judeo-Christian tradition and Anglo-Saxon customary law.[12] Family autonomy is often but not always equated with parental authority.[13] Parental authority for this purpose refers to the deference of the State to the right of parents to make child rearing decisions.[14] At common law, minor children were in effect the chattels or property of their parent who had virtually the unfettered right to rear them as they saw fit.[15] Over time, constraints increasingly have been imposed upon the power of parents over their minor children, and minor children increasingly are recognized as having independent rights.[16] Yet, minor children are still largely subject to the authority of their parents. In a long series of decisions, the United States Supreme Court has commented upon the importance of family autonomy and parental authority and extended federal constitutional protection, albeit not absolute protection, to family autonomy and parental authority.[17]

The parental consent requirement also seems, at least somewhat, to be designed to protect parents from financial liability arising from the provisions of health services, without their consent, to their children and to assure the availability of a payment source for such services. Parents are legally responsible for the support and maintenance of their minor children. This duty commonly has been interpreted to entail their financial liability for necessary goods and services, known as "necessaries" for their minor children.[18] In most cases where a parent has consented to health services for his or her minor child, the parent will assume the responsibility of payment for those services. In cases where the parent has not consented to the services, the parent will not usually be financially liable for the services unless they are determined to be "necessary."[19] In the event that the parent is not financially liable, the health care provider may attempt to collect from the minor child, but this can prove difficult inasmuch as the minor may have the power to disaffirm the contract for services and in view of the fact that the minor may have little or no financial resources to pay for services.[20]

SECTION TWO
EXCEPTIONS TO PARENTAL CONSENT REQUIREMENT

While the parental consent requirement has a long history, there are recognized exceptions to this requirement which have an almost equally long history. Over the years, the number of exceptions has grown significantly and has almost overwhelmed the parental consent requirement. Some of these exceptions are relatively narrow, and others are relatively broad. Some of these exceptions apply to minors regardless of their age, and others are directed at or impact primarily adolescent minors.

Exceptions to the parental consent requirement tend to fall into the following four categories: (1) exceptions arising out of the jurisdiction of juvenile and family courts over abused and neglected minors; (2) exceptions related to the status and characteristics of individual minors; (3) exceptions for emergency situations; and (4) exceptions for specific health problems and services.[21]

I. Exceptions Arising from Juvenile and Family Courts' Jurisdiction over Abused and Neglected Minors

Although parental consent traditionally has been required for provision of health services to minors, juvenile and family courts traditionally have had the power to intervene to secure health services for children where parental refusal to consent to the provision of services constitutes medical neglect. In all states juvenile and family courts have jurisdiction over abused and neglected children. Abuse and neglect are defined in a variety of ways, with the former generally referring to the intentional infliction of harm upon a child by his or her parents, guardian or custodian, and the latter generally referring to a failure on the part of the parents, guardians or custodians to provide adequate care and protection for a child.

The basis for state coercive intervention in the lives of children and families through the exercise of juvenile and family court abuse and neglect jurisdiction is the state's parens patriae power. This power is said to stem from the state's authority to promote the welfare of children and individuals who are mentally incompetent and who lack the capacity to act in their own best interests.[22]

Most juvenile and family court acts expressly define neglect so as to include failure to provide adequate medical/health care.[23] Some acts do not have express medical neglect provisions, but contain broad definitions of neglect that can be interpreted to cover failure to provide adequate medical/health care.[24] In many instances where medical neglect is alleged the parents' refusal to consent to care is based upon religious convictions. Judicial intervention typically occurs when the minor's life is or will be threatened because of lack of care,[25] and courts typically tend to be reluctant to intervene in non-life threatening situations.[26]

It should be noted that the jurisdiction of juvenile and family courts over medically neglected children can be and is exercised over minors of all ages rather than just adolescent minors. It should also be noted that judicial intervention is not directed at giving the minors autonomy as to health care decision making, and judicial opinions usually do not discuss or even mention the minors' wishes.[27] Rather, judicial intervention, if it occurs, has the effect of substituting the judge for the parent as the health care decision maker.

II. Exceptions Related to Status and Characteristics of Individual Minors

Another category of exceptions to the requirement of parental consent to health services for minors consists of exceptions that are related to the status and characteristics of individual minors. This category may in turn be divided into the following subcategories: (1) exceptions for emancipated minors and independent minors, and (2) exceptions for "mature" minors.

A. Emancipated and Independent Minors

One well-established exception to the requirement of parental consent involves minors who are referred to as "emancipated minors". One noted authority has defined emancipation as "the legal process by which a child is released from the control and authority of his parent."[28] Unfortunately, emancipation is a somewhat murky and confused area of the law.[29] Emancipation is an outgrowth of a common law doctrine. Based upon this doctrine, courts, without explicit statutory authorization, have issued decrees freeing parents and their children from the reciprocal obligation that attaches to the parent-child relationship.

Emancipation may be found to have occurred in accordance with an express agreement under which a minor's parent or parents relinquish their rights with respect to the minor in exchange for the extinguishment of their responsibilities with respect to the minor. Alternatively, emancipation may be implied from the acts of the parties. Some courts have been willing to rely upon the minor's acts alone to support a finding of emancipation, but most courts require the parent to consent, either explicitly or implicitly, to emancipation.

In determining whether emancipation has taken place, a wide variety of factors are relevant. The main indicia of emancipation are the marriage of a minor, the minor's induction into the armed services, establishment by a minor of a home away from that of his or her parents, and a minor's economic independence from his or her parents.[30]

Emancipation determinations by the courts are heavily influenced by the legal context in which they arise. The emancipation doctrine was originally developed in the context of claims by parents to wages earned by their children. However, the doctrine, as it evolved, came to be utilized in other contexts, such as the child's right to support from a divorced parent and the child's right to sue a parent for a tort.

Under the common law doctrine of emancipation, emancipation may be complete or partial, and it may also be permanent or total. Therefore, emancipation of a minor based upon the common law doctrine may or may not result in a minor having the right to consent to health service.

A little under half of the states now have statutes providing for court-ordered emancipation of minors. These statutes vary in terms of the criteria for emancipation and the procedures to be followed in connection with an emancipation proceeding. Most of these emancipation statutes do not expressly provide that one of the effects of an emancipation decree is to allow the minor to consent to health services on his or her own behalf without parental permission,[31] but there are a few emancipation statutes that explicitly state that a court-ordered emancipation removes the disabilities of minority including the requirement of parental consent to health services.[32]

In addition, a few states have statutes under which a minor may become emancipated through certain designated acts on the part of the minor's parents, the minor, or both.[33] These statutes do not require a judicial proceeding to determine if a minor is emancipated and the issuance of a judicial decree for a minor to be deemed emancipated. Only one of these statutes specifically declares that the emancipated minor may consent to health services,[34] and such consent is authorized under very limited circumstances.

Finally, several states have statutes that simply state that an "emancipated minor" may consent to health services.[35] It is unclear under these statutes what constitutes emancipation, how it is to be determined, and by whom it is to be determined.

In addition to statutes authorizing emancipated minors to consent to health care, there are statutes that authorize minors, who have attained varying degrees of independence, to consent to health services. Since these statutes do not utilize the term "emancipation" or "emancipated," they are perhaps best characterized as "independent minor" statutes.

Over one-half of the states have statutes allowing minors who are parents to consent to health care for themselves, their children, or both;[36] about one-half of the states have statutes allowing a married minor or minors who are or have been married to consent to health care;[37] about one-fifth of the states have statutes allowing minors who are living apart from their parents and managing their own financial affairs to consent to health services;[38] a few states have statutes allowing minors in the military to consent to health services;[39] and a few states have statutes allowing minors who have graduated from high school to consent to health services.[40]

The emancipated minor and independent minor exceptions to the parental consent requirement impact primarily, if not exclusively, upon adolescent minors because it is adolescent minors who are most likely to be able to achieve complete or substantial independence from their parents. Under these exceptions, the focus is the minor's independence from his or her own parents, not the minor's capacity to make health care decisions, although the former may in effect be a surrogate for the latter. These exceptions seem to reflect legislative judgments that the minor, rather than the minor's parents, is in the best position to make health care decisions for himself or herself when the minor is not part of a functioning family, or when the minor's parents exercise little or no control over him or her.[41]

B. Mature Minors

Another exception to the requirement of parental consent is the "mature minor" exception. Under this exception, unemancipated minors found to have attained a certain degree of maturity may consent generally to health services. The mature minor exception was recognized by state courts beginning in the early 1900s.[42] However, there are relatively few state decisions dealing with this exception.[43] Based upon an analysis of the state decisions and related commentary, one authority has stated that the factors supporting a determination of maturity for purposes of health care decision making are as follows:

> (1) the treatment is undertaken for the benefit of a minor rather than a third party; (2) the particular minor is near the age of majority; (3) the minor is considered to have sufficient mental capacity to understand fully the nature and importance of medical steps proposed; (4) the procedures are characterized as less than "major," not "serious" or not overly "complex."[44]

More recently, the United States Supreme Court has applied the mature minor doctrine in a series of decisions dealing with the right of a minor to family planning services and abortions.[45]

Since the mature minor exception has been enunciated primarily by courts rather than state legislatures, there are only a small number of mature minor statutes. Three states have statutes explicitly authorizing mature minors to consent to health services[46] and two states have statutes which are somewhat ambiguous but could be construed to constitute mature minor consent statutes.[47]

The mature minor exception is not by its terms limited to a particular age group but the "maturity" contemplated by this exception is probably most often to be found in minors in middle and late adolescence. Underlying this exception is a rejection of the presumption of a minor's incompetency and an assumption that the minor lacks decision-making capacity based solely on the minor's chronological age, and the exception allows for individualized determinations of the actual decision-making capacity of minors.

III. Exceptions for Emergency Situations

Still another category of exceptions to the parental consent requirement consists of exceptions to emergency situations. Just as it is well established that physicians or other health care providers may furnish medical or surgical care to an adult in an emergency situation without his or her consent (under some circumstances),[48] they may furnish such care to children in such situations without parental consent. The emergency exception to the parental consent requirement is the outgrowth of the need to provide immediate care to the child in an emergency, in order to protect the child's life or health, when the child's parents were unavailable or could not be easily located.

The emergency exception was originally enunciated by the courts.[49] In over half of the states, there are now statutes codifying the emergency exception to the parental consent rule.[50] These statutes take several forms. Some simply authorize emergency care of a minor without parent consent, others state that a physician or other health professional who treats a minor in an emergency without parental consent is relieved from liability, and still others provide that a minor may consent to emergency care.[51]

IV. Exceptions for Specific Health Problems and Specific Types of Services

The last category of exceptions to the parental consent requirement consists of exceptions for specific health problems or specific types of services. This category can in turn be divided into the following subcategories: (1) exceptions for health services related to sexual activities, (2) exceptions for health services related to alcohol and drug abuse, and (3) exceptions for mental health services.

A. Exceptions for Health Services Related to Sexual Activities

1. Family Planning Services and Abortion Services

Access to family planning services and abortion services by adolescents is governed by federal constitutional law as interpreted by the United States Supreme Court and the lower federal courts. In a series of decisions, the Supreme Court has recognized that an individual has a constitutionally protected "right to privacy" encompassing decisions with respect to procreation and bearing of children, albeit this right is not an absolute right.

In the landmark case of Griswold v. Connecticut,[52] the Supreme Court held that state regulation of use of contraceptives by married persons invaded "the zone of privacy created by several constitutional guarantees," and the Court struck down as unconstitutional a state criminal statute prohibiting the use of contraceptives by married persons. In Eisenstadt v. Baird,[53] the Supreme Court held that unmarried as well as married persons had a right to privacy with respect to contraceptive use.

A subsequent Supreme Court decision, Carey v. Population Services International,[54] established that minors as well as adults have a constitutionally protected right to privacy as to the use of contraceptives. The Court specifically held unconstitutional a state statute prohibiting the sale or distribution of contraceptives to minors. The Court indicated that "[s]tate restrictions inhibiting privacy rights are valid only if they serve any significant state interest . . . that is not present in the case of an adult."[55]

A little under one-half of the states have statutes providing that minors may obtain what are variously described as contraceptives, birth control services or services for the prevention of pregnancy.[56] A caveat is that these statutes either explicitly exclude from this mandate sterilization[57] and abortion or they have been or could be interpreted as doing so.[58] Some of these statutes place various restrictions on a minor's access to these services.[59] Among the common restrictions are that the minor be referred from a designated source, that the minor be of a certain minimum age or possess a certain maturity and intelligence, and that the minor would suffer detrimental health consequences if the services are not provided.

In Roe v. Wade,[60] the Supreme Court held that the privacy right recognized in Griswold and Eisenstadt was broad enough to encompass a woman's decision as to whether to terminate her pregnancy, and the Court invalidated on constitutional grounds, state criminal statutes prohibiting non-therapeutic abortions at any stage of pregnancy. However, the Court held that a state had legitimate interests that could justify state regulation imposing some limitations upon performance of abortions.[61]

The Supreme Court has issued several subsequent decisions concerning a minor's right to an abortion and parental involvement in the abortion decision of a minor.[62] In these decisions the Court extended constitutional protections with respect to the abortion decision to minors. Although the Court did not find the parental consent requirement for a minor's abortion to be per se impermissible, the Court ruled that a minor's parents cannot be given an absolute or blanket veto of the minor's decision to undergo an abortion. Accordingly, the Court held that a parental consent requirement must be coupled with an alternative procedure for judicial approval, often referred to as a judicial bypass, under which a minor can secure judicial approval for an abortion if it can be demonstrated that the minor is mature enough to make the abortion decision or that the abortion would be in her best interests. In addition, the Court has indicated that the judicial bypass procedure must assure a confidential and expeditious proceeding.

In the wake of Roe v. Wade and its progeny invalidating a number of state criminal abortion statutes, some states moved to regulate abortion to the extent possible. In about a quarter of the states, statutes were enacted requiring parental consent in order for a minor to obtain an abortion.[63] Some of these state statutes have been invalidated or are currently being challenged on federal constitutional grounds.[64] Thus, not all of the state statutes providing for parental consent to a minor's abortion are currently being enforced.[65]

It must be stressed that a recent United States Supreme Court case, Webster v. Reproductive Health Services,[66] decided July 3, 1989, casts doubt on the continuing validity of past Supreme Court decisions dealing with abortion and the future directions of the Court with respect to abortion. At issue in Webster was the constitutionality of the provisions of a Missouri law restricting abortions.[67] A majority of the Court--five justices--voted to uphold the constitutionality of the Missouri law. However, it is difficult to generalize about the position of these justices on the constitutionally permissible scope of state regulation of abortion based on the Webster ruling because the ruling was not accompanied by a single majority opinion. Rather, this ruling was based on a plurality opinion and two separate concurring opinions, setting forth different and complicated reasons for the ruling. Nevertheless, the thrust of the Webster ruling and the plurality and concurring opinions was to increase the leeway of states in restricting abortions, and although Roe v. Wade was not overruled, the opinions in Webster suggest that four and possibly five of the justices disagree, at least in part, with the Roe decision.

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Parental consent to abortion requirements was not considered in the Webster case, but to the extent it increases the state's ability to restrict abortion, it may have a negative effect on the access of minors as well as adults to abortion. Moreover, there are two cases currently before the Court that address the constitutionality of state imposed requirements of parental notification for abortions by minors and the decisions in these cases could have implications for state-imposed parental consent as well as notification requirements, depending on their outcomes and the rationales advanced for these outcomes.[68]

2. Pregnancy Related Health Services

Provision of pregnancy related health services to minors is another area in which many state legislatures created a statutory exception to the parental consent requirement. Over one-half of the states have statutes specifically authorizing minors to consent to pregnancy-related health services.[69] The effect of these statutes is to permit female minors to obtain testing to determine pregnancy without parental consent and pregnant female minors to obtain prenatal care and delivery services without parental consent.

Only one of these minor consent statutes imposes a minimum age requirement.[70] Since, however, these statutes are directed at pregnant minors, they are in effect adolescent consent statutes.

3. Health Services Related to Venereal, Sexually Transmitted and Infectious Diseases and AIDS

Almost all states have enacted legislation specifically authorizing the delivery of health services to minors without parental consent for "venereal disease" or for "sexually transmitted disease," which includes but is not limited to veneral disease. Over two-thirds of the states have statutes that permit minors to consent to health services for venereal disease or to receive such services without parental consent;[71] about one-quarter of the states have statutes that permit minors to consent to health services for sexually transmitted disease or to receive such services without parental consent[72] and in one state there are two statutes, one of which allows minors to consent to health services for venereal disease and the other of which allows minors to consent to health services for sexually transmitted disease.[73]

A few states have also enacted legislation specifically authorizing the delivery of health services to minors without parental consent for "infectious, contagious, communicable and reportable diseases" or some variant thereof which usually includes but is not limited to venereal and sexually transmitted diseases. In some states there is a statute covering some variant of "infectious, contagious, communicable and reportable diseases," rather than a statute or statutes covering venereal disease or sexually transmitted disease.[74] In other states, there is both a statute covering some variant of "infectious, contagious, communicable and reportable diseases" and a statute covering venereal disease or sexually transmitted disease.[75]

The aforementioned statutes do not expressly cover testing for Human Immunodeficiency Virus (HIV) which has been identified as the virus which causes Acquired Immune Deficiency Syndrome (AIDS). However, statutes using the terms "sexually transmitted disease" or some variant of infectious, contagious, communicable and reportable diseases" may cover or could be interpreted to cover HIV testing depending upon how these terms are defined for purposes of these statutes. Only a few states thus far have enacted legislation that directly authorizes minors to consent to or to receive such testing without parental consent.[76]

Most of the aforementioned statutes allow minors to consent to services or to receive services without parental consent regardless of their age. A little under one-quarter of these statutes impose a minimum age, either twelve years of age,[77] or fourteen years of age,[78] for consent to services or receipt of services by minors. The fact that these statutes, for the most part, set no age limit or a very low age limit for provision of health services to minors for venereal, sexually transmitted and infectious diseases without parental consent, appears to stem from a legislative recognition that society has a critical interest in facilitating and encouraging access to health services to reduce the spread of disease among its citizens.

B. Exceptions for Health Services Related to Drug and Alcohol Abuse

Health services related to drug and alcohol abuse for minors is still another area in which state legislatures have acted to create a statutory exception to the parental consent requirement. Almost all states have statutes specifically authorizing minors to consent to drug and alcohol related health services or to receive such services without parental consent. Only five states and the District of Columbia do not have such statutes.[79]

Two-thirds of the states have statutes specifically covering health services related to both drug and alcohol abuse and dependency;[80] one-fifth of the states have statutes covering health services related to drug abuse but not alcohol abuse;[81] and two states have statutes covering health services related to alcohol abuse but not drug abuse.[82]

The majority of statutes that create an exception to the parental consent requirement with respect to health services for drug and alcohol abuse do not impose minimum age requirements. A little over one-quarter of such statutes provide that a minor must have reached a designated age, ranging from twelve years of age to sixteen years of age, in order to consent to or to receive services.[83]

These statutes would appear to represent an acknowledgment on the part of state legislatures of the seriousness of drug and alcohol abuse problems among adolescent minors. They further would appear to be the product of a concern on the part of state legislatures that minors may not obtain care related to such abuse if they have to secure parental consent for such care because "communications" between parents and minors regarding alcohol or drug abuse may "be strained or nonexistent."[84]

C. Exceptions for Mental Health Services

In a number of states, statutes pertaining to mental health services for minors have been enacted. These statutes are concerned with the provision of outpatient services, the provision of inpatient services, or both.

A little under one-half of states have statutes that create an exception to the parental consent requirement for outpatient mental health services for minors.[85] These statutes usually contain age restrictions so as to allow only adolescent minors to consent to mental health services or to receive such services without parental consent. Underlying these statutes appears to be a legislative realization that adolescent minors who have mental health problems may be deterred from seeking needed services by a parental consent requirement because of a reluctance to reveal those problems to their parents.

Inpatient mental health services, as opposed to outpatient mental health services for minors, present special problems. Commitment to a mental health institution or facility for diagnosis or treatment services may be involuntary or voluntary. Since involuntary commitment results in a deprivation of liberty, certain substantive criteria for commitment must be met and certain procedures of a due process nature must be observed in order to insure that commitment is necessary. However, such safeguards are not mandated for voluntary commitment.

A concomitant of the parental consent requirement for the provision of health services to minors has been that parents have the power to decide whether the minor shall receive services regardless of the minor's desire or need for services. In the context of mental health services this power often has been reinforced by allowing a parent to make a voluntary commitment of his or her minor child to a mental institution or facility.

In Parham v. J.R.[86] the Supreme Court reviewed the constitutionality of a state statute allowing voluntary commitment of a minor by his or her parent that had been asserted to be violative of the minor's constitutionally protected liberty interests. The Court rejected the contention that an adversary hearing was required to decide whether a minor may be committed by his or her parents in order to protect the minor, but the Court did hold that the risk of error in the parental decision to commit a minor was sufficiently great as to call for an inquiry by a neutral fact finder to determine if the statutory criteria for admission were met.

About two-thirds of the states currently have statutes that allow parents to make a voluntary commitment of a minor child.[87] These statutes vary substantially in the safeguards they provide against inappropriate use of hospitalization or institutionalization to manage "troublesome" minor children who do not have severe mental health problems.[88] As one commentator has observed:

> These statutes range from those that apply virtually the same procedural protections and substantive commitment criteria to minors as to adults to those that require little more than the Parham minimum. The dimensions on which state laws vary include: the extent to which they require any type of review prior to the admission of a minor beyond that performed by admitting staff; the timing of such review; whether such review is mandatory or triggered by petition; the form and process of such review and the concomitant rights of prospective patients (such as right to counsel); the substantive standards applied in such review; the role, if any, minors of various ages are given in choosing or refusing admission and in triggering any review process; and the extent to which admissions to private facilities are governed by statute. In general, however, minors are significantly less able than are adults to resist mental hospitalization sought for them by others. [Citations omitted.][89]

Regarding the authority of minors to commit themselves to a mental health institution or facility, one-half of the states have enacted legislation authorizing minors to apply for admission to an institution or facility without parental consent.[90] Most of these statutes have age limits, with the most common age limit being sixteen years of age or older.[91] Finally, a few states have statutes that require both the minor's consent and a parent's consent for inpatient services.[92]

SECTION THREE
CONFIDENTIALITY AND PARENTAL NOTIFICATION

I. PRINCIPLE OF CONFIDENTIALITY

The importance of confidentiality in the provision of health services has long been acknowledged. It is generally accepted that confidentiality of the physician-patient relationship as well as the relationship between other types of providers of health services and their patients or clients is "essential to a patient's trust in a health-care provider and to a patient's willingness to supply information candidly for his or her benefit."[93]

Courts and legislatures have sought to protect confidentiality in the provision of health services through the establishment of a physician-patient privilege as to communications between physician and patient and through the establishment of privileges as to communications between other types of health care providers and their patients and clients.[94] There is also a developing case law imposing liability on physicians for unauthorized disclosure of confidential information about their patients.[95] Nevertheless, health care professionals are legally obligated to disclose information obtained from their patients and clients in situations where there is a strong societal interest in disclosure, such as reporting of cases of suspected child abuse to the public child welfare authorities.[96]

II. PARENTAL NOTIFICATION REQUIREMENTS

By and large, case and statutory law does not address the confidentiality of the relationship between health service providers and minors and the disclosure of confidential information by health service providers to the parents of minors or other third parties. However, there is one issue pertaining to confidentiality and disclosure, namely, notification of parents of a minor's decision to obtain health services or the minor's actual receipt of health services, which has become a "legal" issue. As long as the consent of parents was legally required for the provision of health services to a minor, the issue of notification of parents did not arise. However, in the process of carving out exceptions to the parental consent requirement, courts and legislatures have sometimes, but not always, replaced the parental consent requirement with parental notification requirements.

The justification for requiring that parents be notified of the decisions of their minor children to obtain services are essentially the same as, or at least very similar, to the justifications for requiring that parents consent to health services for their children. One major justification for notification requirements is to assure that parents play an appropriate "guiding role" in counseling their children about health care decisions, in view of the presumed incompetency of minors to make these decisions due to their assumed lack of decision-making capacity.[97] Another asserted major justification for notification requirements is to bolster parental direction and control of their minor children and thereby to maintain the family structure.[98]

Parental notification requirements are found in connection with certain of the previously discussed categories of exceptions to the parental consent requirement. These requirements are primarily associated with the exceptions for specific types of health services or specific types of health problems, including: (1) health services related to sexual activities, (2) health services for drug and alcohol abuse, and (3) mental health services. Parental notification provisions also appear in some statutes creating exceptions to the parental consent requirement for emergency situations, and in some statutes creating exceptions to the parental consent requirement that are related to the status and characteristics of individual minors, namely, exceptions for emancipated minors, independent minors and mature minors.

A. Parental Notification and Provision of Health Services Related to Sexual Activities

1. Abortion Services

The issue of parental notification has generated a great deal of attention primarily in relation to the access of minors to abortion services. As it has been pointed out, a series of Supreme Court decisions have established that minors as well as adults have a constitutionally protected right with respect to a decision as to whether to have an abortion. As a result, the Court has begun to delineate the constitutionally permissible scope of required parental involvement in abortion decisions by minors, not only in the form of a requirement of parental consent to the provision of abortion services, but also in the form of a requirement of parental notification of the provision or intended provision of abortion services.

The Court has dealt less extensively with parental notification than with parental consent in cases involving abortion services for minors. However, in H.L. v. Matheson,[99] the Supreme Court sustained the constitutionality of a state statute requiring a physician to notify, "if possible" the parent of a minor upon whom an abortion is to be performed. In a narrow decision, the Court held that the parental notification statute was not unconstitutional as applied to a minor living with and dependent on her parents who is not emancipated and who has made no claim or showing as to her maturity or as to her relationship with her parents. The Court left open the question of whether the statute would be constitutional as applied to emancipated or mature minors.

It must be reiterated that the federal constitutional law concerning the permissible scope of state regulation of abortion as interpreted by the United States Supreme Court is in flux, and the Supreme Court's decision in Webster v. Reproductive Health Services[100] would appear to give the states more power to restrict abortions. Moreover, the Court currently has under review the constitutionality of two different state statutes requiring parental notification of a minor's decision to obtain an abortion.[101]

At the present time, in a little under one-quarter of the states, there are statutes requiring parental notification of a minor's abortion decision.[102] In the wake of Webster, there has been increased debate as to whether parental notification of abortions involving minors should be required[103] and the Supreme Court's decisions as to the constitutionality of the state statutes requiring parental notification that it is now reviewing may furnish an impetus for additional state legislative activity aimed at requiring parental notification.

2. Family Planning Services

The issue of parental notification has generated a great attention in relation to the provision of family planning services as well as in relation to the provision of abortion services to minors. The Supreme Court has not addressed directly the constitutionality of involving parents through a parental notification requirement in a minor's decision as to whether to obtain family planning services. Only a few of the state statutes permitting minors to consent to family planning services have provisions pertaining to parental notification of the minor's application for receipt of such services, and almost all of these statutes allow but do not compel notification.[104]

The U.S. Department of Health and Human Services has unsuccessfully attempted to promulgate regulations concerning parental notification, applicable to family planning clinics receiving federal funds under Title X, which would have required these clinics to notify parents of unemancipated minor children when contraceptives were prescribed. These regulations aroused a great deal of controversy and were the subject of litigation in the federal courts. Two federal courts enjoined the Department from implementing them; the Department then decided not to appeal from these court decisions; and as a consequence the regulations were not implemented.[105]

3. Pregnancy Related Health Services

The many state statutes authorizing minors to obtain pregnancy related health services without parental consent generally do not require parental notification. One state has a statute that explicitly provides that prenatal care may be furnished without parental notification;[106] somewhat under one-third of the states have statutes that have no provisions regarding parental notification;[107] and about one-fourth of the states have statutes that provide for parental notification at the discretion of health professionals.[108]

4. Health Services for Venereal, Sexually Transmitted and Infectious Diseases and AIDS

The many state statutes authorizing minors to obtain testing and treatment for venereal, sexually transmitted and infectious diseases without parental consent generally do not require parental notification. A few states have statutes that specifically state that services may be furnished without parental notification;[109] nearly one-third of the states have statutes that give health professionals general discretion to notify or discretion to notify under certain specified circumstances;[110] nearly two-thirds of the states have statutes that contain no notification provisions;[111] and only one state has a statute that mandates notification and such notification is mandated under limited conditions.[112]

Under the relatively small number of state statutes permitting minors to be tested and treated, without parental consent, for the Human Immunodeficiency Virus, which causes AIDS, parental notification is not required. A few states have statutes with provisions giving health professionals general discretion to notify or discretion to notify under specified circumstances;[113] one state has a statute that contains no notification provision;[114] and one state has a statute requiring confidentiality unless test results are positive, in which case notification is required.[115]

B. Parental Notification and Provision of Health Services Related to Drug and Alcohol Abuse

There is considerable variation regarding parental notification in the many state statutes allowing minors to consent to health services related to drug and alcohol abuse or to receive such services without parental consent, and this variation makes generalization difficult. Some statutes require confidential treatment under specified circumstances;[116] other statutes leave notification to the discretion of the health professional or to the discretion of the health professional under certain specified circumstances;[117] still other statutes are silent as to notification;[118] a few statutes require notification attempts;[119] and a few statutes require notification or require notification under certain specified circumstances.[120]

It should be noted that The United States Department of Health and Human Services has promulgated a final rule for federally funded alcohol and drug abuse programs that contains a provision with respect to parental notification of a minor's application for alcohol and drug abuse services. This rule prohibits parental notification of a minor's application for alcohol and drug abuse services without the minor's consent unless the minor "lacks the capacity to make a rational choice" about parental notification and the minor's "situation poses a substantial threat to the physical well-being of the minor or other person" that may be alleviated by parental notification.[121] The comments on the rule indicate that even in states where parental consent for treatment is required, the rule prohibits parental notification without the minor's consent, but the comments indicate that rule does not "compel" a program to provide services without parental consent.[122]

C. Parental Notification and Provision of Mental Health Services

The many state statutes under which minors can consent to mental health services or receive mental health services without parental consent vary in terms of parental notification. The majority of statutes dealing with outpatient services are silent as to parental notification.[123] The remainder specify that treatment should be confidential,[124] that notification is at the discretion of health professionals,[125] or mandate notification under designated limited conditions.[126] The majority of statutes dealing with inpatient services similarly do not have parental notification provisions,[127] and the remainder provide for notification at the discretion of health professionals,[128] or provide for notification under certain circumstances.[129] Perhaps, not surprisingly, inpatient statutes are more likely than outpatient statutes to require or permit parental notification.[130]

D. Parental Notification and Provision of Emergency Health Services

While parental notification provisions appear primarily in state statutes authorizing minors to obtain specific types of health services, or health services for specific types of health problems even in the absence of parental consent, parental notification provisions sometimes appear in state statutes authorizing minors to obtain health services in emergency situations without parental consent. Only a handful of these statutes have some sort of notification provisions.[131] However, the prevailing pattern is for state statutes that create an exception to the parental consent requirement in emergency situations is to have no provisions as to notification.[132]

E. Parental Notification and Provision of Health Services to Emancipated, Independent and Mature Minors

Parental notification provisions also sometimes appear in state statutes authorizing emancipated minors, independent minors or mature minors to obtain health services without parental consent. Turning first to "emancipated minor statutes," here again, the prevailing pattern is for these statutes to be silent as to notification,[133] with just a few of these statutes containing various kinds of notification provisions.[134] Basically the same pattern is found in state "independent minor statutes" applicable to married minors,[135] minors who are parents,[136] minors living apart from their parents and managing their own financial affairs,[137] minors in the military,[138] and minors who have graduated from high school.[139] Finally, this same pattern is found in the "mature minor statutes."[140]

SECTION FOUR
IMPACT OF PARENTAL CONSENT AND NOTIFICATION REQUIREMENTS

Having described the body of law relating to parental involvement in the making of decisions about health care for minors, there remains to be examined the impact of laws requiring parental consent to health services for minors or requiring parental notification of the provision or intended provision of health services to minors. More specifically, the impact of these requirements on the access of minors to health services and their utilization of health services must be examined.

One factor that affects the impact of legally mandated parental consent and notification requirements is whether and to what degree there are actual or potential conflicts between minors, the parents of minors and health professionals in the making of health care decisions involving the minor. It is important to recognize at the outset that these legal requirements do not become critical, or even relevant, unless there are such conflicts. It does appear that how a health professional presents information to a minor and the minor's parents and what kind of relationship a health professional has with the minor and the minor's parent may have a decisive influence upon the nature and extent of such conflict. If a health professional has knowledge, skills and experience regarding the management of potential conflicts, they may well be avoided.[141]

But conflicts between minors, their parents and health professionals over health care decisions do in fact occur. There is some evidence that suggests that, in a significant number of cases there are actual or potential conflicts over the provision of family planning services and abortion services to adolescent minors.[142] What is not known is whether and to what degree there are actual or potential conflicts in the making of decisions about other health services which minors, particularly adolescent minors, need and want.

Another factor that affects the impact of laws requiring parental consent or notification for the delivery of health services to minors is whether and to what degree there is compliance or non-compliance with these requirements in providing health services to minors by health service providers. Laws might be expected to evoke compliance because they carry with them sanctions for violations and because they constitute a societal declaration that certain conduct is right or wrong. However, laws differ in their effectiveness. Non-compliance with laws requiring parental consent or notification, on the part of health professionals might occur due to ignorance or misunderstanding of these legal requirements. Non-compliance on the part of health professionals might also occur because these requirements, at least as applied to particular factual situations, are at odds with the ethical standards of their profession as expressed in statements of professional organizations, or their personal ethical values and norms.[143] Unfortunately, there do not appear to be empirical studies and data concerning compliance and non-compliance with legally mandated parental consent or notification requirements that would permit valid conclusions about the extent of compliance and non-compliance among health service providers.

To the extent that legally-mandated parental consent and notifications are adhered to by health professionals, the issue arises as to whether and to what degree they create barriers and access to health services and reduce utilization of needed health services. One scenario is that a significant number of parents frequently and strongly object to the provision of health services, or at least to the provision of services associated with sexual activity, substance abuse, and mental health problems. A related scenario is that a significant number of minors, particularly adolescents, will be unwilling to reveal to their parents their need for health services, or at least their need for services associated with sexual activity, drug and alcohol abuse and mental health problems, and so will delay seeking health services or will be deterred from seeking those services.

Although the legislatures and courts appear to regard the requirement of parental notification as less onerous than the requirement of parental consent from the standpoint of an adolescent, it is not clear that adolescents distinguish between these requirements. It has been observed that it is "immaterial to the adolescent just when parents learn (before or after the fact of treatment) or how they learn (by mandatory consent, by notification, or by inadvertent disclosure through parental reading of the health record)."[144]

Several empirical studies concerning the impact of parental consent and notification requirements on the access of minors, especially adolescent minors, to abortion services and family planning services and their utilization of these services, indicate that such requirements create access and utilization barriers.[145] But what cannot be said with certainty is the extent to which the findings of these studies can be extrapolated to the delivery of other types of needed health services to minors.

One other problem related to the impact of parental consent and notification requirements is deserving of mention. Even if the laws in a given jurisdiction do not require that a parent consent to health services for a minor and/or do not require that the parent be notified of the provision or intended provision of health services to a minor, it does not necessarily follow that health services will be provided to minors without parental consent or notification. Providers of health services, both institutional providers, such as hospitals, clinics and health maintenance organizations, and individual providers, may as a matter of policy or practice, refuse to provide services without parental consent and/or may notify parents of service provision. One reason for such policies or practices may be financial, i.e., the provider may be concerned that the minor will be unable to pay for services provided and that the minor's parents will not pay for services because they have not consented to or been notified of the provision of services.[146] Another reason for such practices and procedures may be that the provider is concerned that failure to obtain parental consent or to notify parents may have negative impact on the effectiveness of services--that is providers may believe that if parents are involved the effectiveness of services will be enhanced or that if parents are not involved the effectiveness of services will be reduced.

PART TWO

MINORS' COMPETENCY TO MAKE HEALTH CARE DECISIONS

SECTION ONE

PRESUMPTION OF MINORS' INCOMPETENCY TO CONSENT TO HEALTH CARE SERVICES AND DEFINITIONAL ISSUES

As it has been pointed out, individuals traditionally have been treated as legally competent or incompetent for purposes of health care decision making based upon their chronological age rather than a determination of their actual capacity for such decision making.[1] Adults are deemed competent as a matter of law to consent to health services. Thus, there is in effect a legal presumption that adults, at least as a class, are competent to consent to health services resting on empirical assumptions that they have the requisite decision-making capacity. This presumption is rebuttable under some circumstances upon a factual showing of actual lack of decision-making capacity due to factors such as mental illness. Minors are deemed incompetent to consent to health services as a matter of law. There is in effect a legal presumption that minors are incompetent, resting on the empirical assumption that minors lack the requisite decision-making capacity. This presumption is not rebuttable by a showing of actual decision-making capacity in the absence of applicable legislatively or judicially sanctioned doctrines or rules specifically permitting such a showing.

The legal concept of competency is central to existing laws governing health care decision making with respect to adolescents. On the one hand, the well-established legal requirement that parents must consent to the provision of health services for their minor children is partially an outgrowth of the presumption of their children's incompetency and the assumptions concerning their lack of decision-making capacity underlying this presumption.[2] Moreover, judicial and statutory parental notification requirements to some degree are derived from this presumption and these assumptions.[3] On the other hand, some exceptions to the parental consent requirement, created by courts and legislatures, represent a rejection of this presumption and these assumptions as applied to some minors under certain circumstances.[4]

The factual validity of assumptions that minors lack the requisite capacity to make health care decisions has been increasingly challenged.[5] Accordingly, the presumption that minors are incompetent to make health care decisions has been increasingly subject to criticism on the ground that it inequitably denies minors, many or most of whom actually have the requisite decision-making capacity, the power to make their own determinations about obtaining health services.[6]

Since assumptions concerning minors' lack of health-care decision-making capacity are empirical in nature, the question of their validity obviously is an empirical issue. It appears that these assumptions largely reflect the intuition of judges and legislators. Hence, it is important to identify empirical research bearing upon the validity of these assumptions, and to evaluate whether such research supports modification or elimination of the presumption that minors are incompetent to make health care decisions.

Before the empirical research bearing on the competency of minors to consent is examined, however, it is necessary to examine two definitional issues: first, the issue of what legally constitutes effective consent to health services, and second what legally constitutes competency to make such consent.

The starting point for an examination of what constitutes an effective legal consent to health services is the doctrine of informed consent. Failure on the part of the physician or surgeon to obtain informed consent from a patient for medical treatment or surgery may give rise to civil liability.[7]

The informed consent doctrine as developed in judicial opinions and codified by legislation does not readily lend itself to a concise summary. Nevertheless, one leading tort law authority has summarized the doctrine as follows:

> The informed consent doctrine is based on principles of individual autonomy, and specifically on the premise that every person has the right to determine what shall be done to his own body. Surgeons and other doctors are thus required to provide their patients with sufficient information to permit the patient himself to make an informed and intelligent decision on whether to submit to a proposed course of treatment or surgical procedure. Such a disclosure should include the nature of the pertinent ailment condition, the risks of the proposed treatment or procedure, and the risks of any alternative methods of treatment, including the risks of failing to undergo any treatment at all. Thus, although the procedure is skillfully performed, the doctor may nevertheless be liable for an adverse consequence about which the patient was not adequately informed.
>
> In addressing the perplexing question of whether the patient needed to know about a particular undisclosed risk in order to make an informed decision, the courts often speak in terms of the materiality of the risk: the doctor's duty is to disclose all risks which are "material." The extent of this duty to disclose has traditionally been based upon a professional medical standard--whether physicians customarily inform their patients about the type of risk involved, or whether a reasonable physician would make the disclosure in the circumstance. Since the use of a professional standard paternalistically leaves the right of choice to the medical community, in derogation of the patient's right

> of self-determination, a number of recent cases have defined the duty in terms of the patient's need to know the information--based on whether a reasonable person in the patient's position would attach significance to the information.
>
> In addition to proving the doctor's failure to provide sufficient information, on whatever standard, the plaintiff must also establish a causal link between the nondisclosure and his harm, by proving that he would not have undergone the treatment had he known of the risk of harm that in fact occurred. Because of the patient's obvious bias in testifying in hindsight on this hypothetical matter, most courts have adopted an objective standard of causation: whether a reasonable patient in the plaintiff's position would have withheld consent to the treatment or procedure had the material risks been disclosed. Other courts have adopted a subjective causation test, as better protecting the essential values underlying the informed consent doctrine, and so have framed the standard in terms of whether the particular plaintiff would have avoided the treatment or procedure had sufficient information been provided. [Citations omitted][8]

While the thrust of the informed consent doctrine is to assure informed health care decision making by individuals, it should be noted that the focus of this doctrine, as it has been articulated and applied, is the duty of health professionals to disclose information to an individual rather than the individual's actual understanding of the information disclosed.

To be effective, consent to health care services must not only be "informed" but must also be "voluntary." Consent is said to be involuntary if it is "given under duress,"[9] but the concept of voluntariness is not well defined.[10]

The primary rationale for the informed consent doctrine is that it promotes the patient's autonomy and protects the patient's right of self-determination.[11] "A related but nonetheless distinct justification for the doctrine is the protection of patients" against depersonalized authoritarian medical treatment.[12] It also has been supported on the ground that it encourages rational decision making.[13]

The informed consent doctrine is intertwined with the concept of competency when it comes to health care decision making. Although the concept of competency is a critical concept with a very long history, neither the courts nor the legislatures have furnished much guidance as to its content and meaning in terms of health care decision making.

In the context of health care decision making by minors, the assumptions concerning the lack of decision-making capacity underlying the presumption of their incompetency has been most fully articulated in a series of United States Supreme Court decisions dealing with the right of minors to obtain contraceptives and abortions without parental involvement and the civil commitment of minors by parents. A thread that runs through these decisions is a concern that minor children do not possess the intelligence, maturity and experience that their parents possess.[14]

Another thread that runs through these decisions is a concern that minors are not capable of making informed and voluntary decisions. The specific concerns in this regard are that they may not understand or appreciate the short or long term consequences of their decisions, that they may be susceptible to interpersonal pressures in making decisions, and that they may make unwise decisions detrimental to their welfare.[15]

Courts and, to a lesser extent, legislatures have come closest to enunciating a standard for determining the competency of minors to make health care decisions in connection with the mature minor exception to the requirement of parental consent. This standard is essentially whether the minor is capable of understanding the nature and consequences of proposed medical or surgical treatment and procedures.[16] However, the standard provides little real assistance for its application in particular cases.[17]

Recognizing the need to define with more specificity a criterion for determining whether a person, including an older minor, is competent to make health care decisions, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research reached the following conclusions and made the following recommendations:

> Three general criteria have been followed [to determine if a patient lacks capacity to make health care decisions]: the outcome of the decision, the status or category of the patient, and the patient's functional ability as a decision maker.
>
> The outcome approach--which the Commission expressly rejects--bases a determination of incapacity primarily on the content of a patient's decision. Under this standard, a patient who makes a health care decision that reflects values not widely held or that rejects conventional wisdom about proper health care is found to be incapacitated.
>
> Using the status approach, certain categories of patients have traditionally been deemed incapable of making treatment decisions without regard to their actual capabilities. Some of these categories of patients--such

> as the unconscious--correspond closely with actual incapacity. But other patients who are presumed to be incapacitated on the basis of their status may actually be capable of making particular health care decisions. Many older children, for example, can make at least some health care decisions, mildly or moderately retarded individuals hold understandable preferences about health care, and the same may be true in varying degrees among psychotic persons.
>
> The third approach to the determination of incapacity focuses on an individual's actual functioning in decision making situations rather than on the individual's status. This approach is particularly germane for children above a certain age variously described as from seven to mid-teens. For example, rather than considering children under the age of majority incompetent to decide unless they come within one of the exceptions created by the statutory and common law, these patients could be regarded as competent unless shown to lack decisionmaking capacity. Similarly, a senile person may have been declared incompetent by a court and a guardian may have been appointed to manage the person's financial affairs, but the functional standard would not foreclose the need to determine whether the senility also negated the individual's capacity to make health care decisions. What is relevant is whether someone is in fact capable of making a particular decision as judged by the consistency between the person's choice and that individual's underlying values and by the extent to which the choice promotes the individual's well-being as he or she sees it.
>
> The Commission recommends that determinations of incapacity be guided largely by the functional approach, that individuals not in certain basic categories (such as under the age of 14, grossly retarded, or comatose) should be assumed to possess decisionmaking capacity until they demonstrate otherwise, and that incapacity should be found to exist only when people lack the ability to make decisions that promote their well-being in conformity with their own previously expressed values and preferences. The fact that a patient belongs to a category of people who are often unable to make general decisions for their own well-being or that an individual makes a highly idiosyncratic decision should alert health care professionals to the greater possibility of decisional incapacity. But it does not conclusively resolve the matter. [Citations omitted][18]

The failure of courts and legislatures to furnish much guidance as to the content and meaning of competency in terms of health care decision making has had important implications for the strategies adopted in empirical studies of the capacity of minors to make health care decisions. Thus, the ambiguity surrounding the concept of competency has posed problems for researchers who have attempted to use an operational definition of competency corresponding to the legal definition of competency.[19]

SECTION TWO
EMPIRICAL RESEARCH AND MINORS' COMPETENCY TO MAKE HEALTH CARE DECISIONS*

The empirical research on the competency of minors to make health care decisions was reviewed for the purposes of this report. A core group of studies was selected that addresses the cognitive development of minors and tested whether they differ from adults in their ability to make health care decisions.[20] The core studies share the following characteristics: they involve health care decision making, participants whose age spans or overlaps the range of 10 to 18 years, comparison groups of adults,[21] and they appear to be methodologically adequate.

In addition, studies that supplement the findings of the core group of studies were reviewed.[22] Some of these studies lack key methodological features of the core group of studies (notably field studies without comparison groups) but nevertheless tell us something worth knowing. Some of these studies address decision-making domains not addressed in the core group and thereby suggest a generalized development of competency--or competencies that vary with the decision domain and are accordingly more limited. And some of these studies deal with other issues, such as the differential vulnerability of minors and adults to social influence of peers, family, or professionals, that are relevant to some degree to the legal requirement that consent to health care must be voluntary to be effective.

I. Empirical Research on Minors' Competence

A. Research Strategies

Since a key presumption of the law is that adults are competent to make health care decisions, whereas minors are incompetent to make health care decisions, it is important to evaluate how valid that presumption is. Three research strategies to test that presumption have been considered. Each of these strategies involves the comparison of minors' decision-making performance with a different standard.

One research strategy for testing adolescents' competence would be to compare their decisions with some model of optimal rationality. However, this strategy would not be helpful because against this criterion even most adults, including professionals, would appear incompetent.

The second research strategy would be to compare adolescents' decisions with an operational definition of what would be considered minimal competence from a legal standpoint. In essence, one would specify what answers or what sort of information processing satisfies the legal requirements for competent decision making, and then one could test groups of minors to see what proportion of them meet or fail to meet that standard. However, this strategy cannot be adopted because courts and legislatures have not provided operational definitions of legal standards for minimally competent decision making. They have done no more than to point to the general content of things about which a decisionmaker ought to have understanding.[23]

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* This section of the report was authored by Michael J. Saks, Ph.D.

The third strategy becomes unavoidable under these circumstances: the comparing of adolescents' decision making to that of adults. Since adults are presumed competent, their decision-making capabilities implicitly set the standard against which the decision-making capabilities of minors are to be judged. If the decision making of minors and adults was found to be indistinguishable, a good case could be made either to lower the age of legally effective consent to an age which corresponds to the empirically informed dividing line, or to propose a new or different rationale for keeping the dividing line at the present age.

Virtually all of the research on this topic recognizes that the standard of comparison is whatever the decision-making ability is of adults. Two important features of the studies which have been reviewed follow from that realization. First, they answer the question, "competence of adolescent decision making compared to what?" with "compared to adults," and they provide comparison groups of adults. Second, they depend only loosely, if at all, on the law's definition of competence. That is, they track in a fundamental way the law's clarity and the law's ambiguity about competence. The law's definition of competence (a) implicitly uses as a reference point whatever and however adults decide and (b) states in fairly broad and general terms what the components are of competent decision making. Thus, test studies provide the opportunity to make the legally relevant comparisons by assembling a group of adults as a basis for comparison and by selecting any appropriate decision task.[24]

What the empirical studies measure cannot be exhaustive of the law's operational definition of competent decision making, which is never stated. But as long as each study measures some aspect of decision making falling inside rather than outside of the legal meaning of competent decision making on which consent is grounded, then each study is within the legal definition, and together the studies sample different relevant aspects of whatever the law means by competence. In short, the studies need not (and most do not) state a definition of competence. It is up to a reader (or a policy-maker) to judge whether a given study has looked at some aspect of decision making which is outside of what the law is concerned about when it speaks of competency to make health care decisions.

One serious problem remains with the unavoidable, ingenious and widely used research strategy described above.[25] While the performance of presumptively competent adults must be what adolescents are compared against, the standard of comparison against which adolescents' decisions are to be compared cannot be the average of the adult group. If the adult average were the bright line below which one were deemed to be incompetent, it would mean that half the adults were incompetent. This means that the standard the law would use has to be somewhere below the adult median, because the law accepts most adults, not only the upper half of decision makers, as competent to decide. But where shall the line be drawn? At the first percentile? The fifth? The tenth? The twentieth? No one can say, of course. But if one could say, the proper significance test would be to compare the adolescent group against an exact hypothesis of whatever that xth adult percentile point came to be. That is, adolescents as a group would be found to be incompetent only if as a group they fell below the specified percentile point on the adult distribution. For example, if all adults below the tenth percentile were what we meant by incompetent decision makers, and each and every adolescent performed at the twentieth percentile of adults, then they would easily satisfy the standard of competence.

None of the empirical studies reviewed attempts to deal with the foregoing problem. Each of the core studies simply tests the adolescent group mean against the adult group mean and asks whether significant differences appear. If a difference between the groups appears, the studies report the difference. But, as discussed above, a finding of significant differences between the adult and the adolescent groups still might well mean that adolescents in general are performing above the standard the law sets for adults. Thus, each of the empirical studies reviewed is using a test of competence which sets an inappropriately high standard for adolescent competence inasmuch as the studies require equivalence with adults in order to be deemed competent.[26]

B. Features of an Ideal Empirical Study

In order to appreciate the value and the limitations of the empirical studies reviewed, it will be helpful to ask what the ideal study would look like. This may assist us to make appropriate adjustments in interpreting and weighing the empirical studies and what we learn from them. The ideal study would have a number of features.

1. Testing of Various Possible Dividing Lines Between Competent and Non-Competent Decision Making

The ideal study would take into account different possible cutting points based on the distribution of adult performance.

This would provide alternative standards for assessing the competence of adolescent groups, for the reasons previously discussed. In addition to providing a standard that more closely approximates the law's standard, this strategy would provide a more informative comparison of adolescent performance mapped against adult performance.

2. Inclusion of an Appropriate Range of Age Groups

Plainly the ideal study would include a group covering the range of adolescent ages (ten years of age to eighteen years of age), and in the ideal study a comparison group of adults would be needed.

However, in the ideal study we might want to include as participants minors representing a very wide range of ages. Inclusion of minors who have not reached adolescence would insure that developmental changes would be discerned (in the event that the decision making of all adolescents is indistinguishable from all adults) as a check on the sensitivity of the measurements to be sure they are capable of detecting real differences.

At least as important, in the ideal study we might want to include adults representing a wide age range. Of the core studies, there is one that includes adults as old as 25 years of age, and there is one additional study that includes adults above 19 years of age. Thus, in these studies only very young adults represent the entire category of "adults." If developmental or experiential and generational differences exist among adults in their late twenties through old age, such differences could not be detected in these studies. If adults in their late teens and early twenties will undergo more cognitive changes with time in making health care decisions, then the adult sample of these studies under represents the average level of adult competence. A sound argument might be made that since the law presumes these young adults are competent, they still are a fully adequate comparison group for the purposes of these studies. But this argument cannot be made if the opposite is true, i.e., if decision-making competence declines over the decades. If adults in their 50's or 60's or 70's develop some kind of decision-making obtuseness, or if experiential differences that are generational make adults in their early 20's more comfortable thinking about matters of technology and probability, then these studies would be pitting adolescents against some of the best decision makers in the broad range of the adult group. This suggestion is more than plausible, since it is consistent with life-span cognitive research.[27] It would follow from this reasoning that it is entirely possible, therefore, that these studies understate the competence of minors to the extent that they do not include much older adults and to the extent that older adults are decreasingly effective health care decision makers.

Another approach to obtaining the most appropriate groups might be to select groups in accordance with their frequency as potential users of the type of health care at issue. If the policy issue is whether decisions concerning abortion may be entrusted to adolescent females, then older adolescent females, such as those 16-17 years of age, would be the important group to study, and their decision-making performance could be compared with 18 year olds who are deemed to be legally competent and are most similar in their social, economic, and health situation to the 16-17 year old group that is of policy concern. Because very young adolescents, such as ten-year-olds, do not generally make abortion decisions, they need not be tested for their ability to make competent decisions about abortion. If this strategy were adopted, the starting point of the ideal study would be to ask what policy-relevant health decisions are at issue, and what are the age distributions of minors who might avail themselves of those services.

3. Valid and Reliable Measurements

The ideal study would, of course, use valid and reliable measurements. Given that the outcome of most of the studies reviewed is a finding of no differences between adolescents and adults, it is important to use research methods that do not preordain this outcome. Measures having low reliability contribute to overall variability, and by increasing within-group variability relative to between-group variability, findings of no difference become likely. Few of these studies use standardized tests which would provide us with known reliability and validity. On the other hand, those studies which find any group differences (e.g., between pre-adolescents and adolescents) demonstrate that they are capable of finding differences that may exist.

4. Large Sample Size

To increase the power[28] to detect true differences among age groupings, the ideal study would also employ a large sample size. Large sample size is, of course, only one device for boosting the power of a test. Another is to set a higher p-level (say .10, .15, or .20) to make it easier to find significant differences rather than keeping it difficult to do so. The principle concern is that one not accept a null hypothesis as true (as many of the studies reviewed imply would be the correct conclusion) unless one is sure that the failure to reject a null hypothesis of no difference between groups is not due to low power. In short, the ideal study would calculate and report the power of the significance tests. The power ought to be at or near .80. None of the core studies report statistical power, which omission is, of course, the conventional reporting style.[29] And although the sample sizes generally appear reasonably large, for present purposes (seeing if the null hypothesis ought to be accepted) they ought to be unusually large--and they are not.

5. Report Within-group Variability

Also related to the issue of statistical power is the within-group variability relative to between group variability. Significant differences between groups is defined as more than a certain ratio of between group variability to within-group (error) variability. If the lack of statistical differences between groups is due to wide intra-age-group variation (that is, both adolescents and adults include people who show much and people who show little decision-making competence), then those within-group differences may become much more interesting and important than the lack of age-related, between-group differences. This might have important policy consequences, depending on how wide the variation is and how central decision-making competence really is to the law. It should be emphasized in this regard that several of the authors of the core studies which were reviewed comment on the wide range of variation within groups.

It should also be noted that modern developmental theory, moving away from a strictly Piagetian stage theory, holds that experience, memory, and information-processing ability, rather than cognitive structure, are the important aspects of the development of cognitive competencies.[30]

6. Inclusion of a Variety of Health-Related Decision-Tasks

The ideal study, would include a variety of health-related decision-tasks. This would insure the generality of age-related findings to the range of relevant health care decisions. Conversely, it would serve as a check on the possibility that the age-competency relationship varies across decision domains. And if that is the case, it would allow a policy-maker to set different minimum age levels for different health decisions.

7. Real Consequences, to the Extent Legal and Ethical

In the ideal study it would be desirable to have decisions being made that carried real consequences for the decision maker, rather than decisions being made in response to hypothetical or simulated decision situations because the former better parallel the circumstances to which one would wish to generalize. None of the core studies reviewed has this feature. Of the other studies reviewed, the few studies which do have this feature lack the comparison groups necessary to be able to know if the minors' decisions are the same as or different from those of adults.

The paucity of "real" decision contexts is unavoidable. The research genre at issue is confronted with the paradox that in order to test whether the law's assumptions are correct, one would have to violate the current rules which reflect and are bound by the current assumptions. Since one normally cannot legally do this, one might approximate it by making the subjects believe that their decisions will have real consequences. But if that is not true, then one is lying to the research participant, and normally that is not considered ethical. Thus, we find that those studies involving real consequences are not making the desired range of comparisons among decision domains, and those studies which do make the desired comparisons ask the participants to make simulated or hypothetical decisions rather than "real" ones.

However, a theory that supposes that cognitive processes change as thinking is done in a "real consequences" versus a "hypothetical" context is a theory that poses a complex interaction such that an age effect would appear in the real but not in the hypothetical context. We do not usually assume that the process of decision-making changes in such a complex manner between situations. Virtually all of legal education and much of medical education proceeds on the assumption that modes of thought developed in a hypothetical context transfer without major reversals to real-consequences settings. In other research genres (e.g., attitude change, jury decision making), the usual finding when field versus simulation comparisons are made is that differences found in the simulated setting tend to fade as the study moves to an increasingly "real world" setting. The usual explanation is that the simulated setting better controls, measures and detects the effects upon which the study is focused. In the field context, the influences of interest are diluted by many extraneous factors. If this held true for the research genre at issue, it would mean that the simulations are more, not less, able to detect differences between age groups, if any exist. Indeed, as we shall see, the greater the verisimilitude of the studies (decisions in real situations, with real consequences), the more children and adolescents appear to be competent decision makers, and the more their decisions resemble those of adults.[31]

8. Data on Process of Decision making; and Diverse Measures of Decision making

The ideal study would be concerned with not only the outcomes of decision making but also the process of decision making, and many of the studies reviewed do, in fact, focus both on outcomes and processes. Even if outcomes are similar across age groups, the processes of reaching those outcomes may differ in important ways, and even if outcomes differ across age groups, the processes of reaching those outcomes may be comparable. On the one hand, courts and legislatures probably should be more concerned with decision processes than decision outcomes. To judge the quality of decisions by their contents really is to betray the concern with competent, rational decision making as rhetoric--as a smoke screen for disagreement over substantive decisions.[32] On the other hand, most of us are more impressed by the similarities or differences of outcome.

9. Include Participants Representing a Wide Range of Sociodemographic Groups

To the extent that decision making varies not only with age, but also with gender, ethnicity, socioeconomic status, family background, intelligence, or experience with the decision-domain, the ideal study would include and measure the effects of these variables.

In light of the probable policy concerns toward which much of the knowledge of decision-making competence may be directed, particularly important variables may be ethnicity, socioeconomic status, and family background. For example, consider the following scenario: Most of the research about competency of minors to make health care decisions is done on children of intact middle-class white families. Few differences are found compared with adult decision making. On the basis of this research it is decided to grant minors the power to make health care decisions in certain domains (especially regarding services related to sexual activity, drug and alcohol abuse services, and mental health services). But we have no way of knowing whether the findings of the studies that have been done would generalize to non-white, non-middle-class children.

The foregoing discussion of an ideal study or studies should not be taken to discount the importance of the studies that actually have been conducted and the knowledge that has been produced by those studies. Rather, it is intended to provide a more complete context for assessing what is learned from these studies and what they may fail to tell us which we nevertheless need to know in order to make informed policy choices.

II. Findings of Empirical Studies

A. Health Care Decision Making and Age: Findings of Core Studies

Although the core studies reviewed vary in geographic location, somewhat in sociodemographic characteristics of participants, in whether or not they are in a "real" health care decision setting,[33] and in the subject matter domain of the decisions, they generally are uniform in their findings. These studies find few differences in health care decision making as a function of age for adolescents as young as 13 or 14 years of age.

1. Non-Differences as a Function of Age

Lewis [1980][34] compared minors and young adults awaiting the results of pregnancy tests in a clinic. Those who learned they were pregnant were faced with the decision whether to have an abortion or deliver a child. Participants were asked to respond to a hypothetical question seeking advice for a similarly situated person. In terms of the decision as to whether to have a child, the study found no differences in knowledge of relevant laws, number or types of people consulted, the advice anticipated from those consulted, or considerations relating to child-rearing ability. Adults were more likely than minors to take into account child-rearing capabilities in making their own decisions than in giving advice to another person. This difference between one's own decisions and hypothetical advice-giving does not suggest lack of ability to think about the issue, but rather a difference in application to self or others.

Weithorn & Campbell [1982][35] presented hypothetical treatment dilemmas and asked participants what decision they would make and the reasons for those decisions. The treatment dilemmas involved four health problems: diabetes, epilepsy, enuresis, and depression. No differences were found for participants aged 14, 18, and 21 years of age. Moreover, the decisions did not differ from those that health professionals said they would recommend for the same problems. These age groups also did not differ from each other on tests of factual understanding of the health problems or appreciation of the consequences associated with various options.

Kaser-Boyd et al. [1986][36] asked adolescents with mild to severe learning and behavior problems to distinguish among risk and benefit factors, as well as irrelevant considerations, with respect to a hypothetical decision to accept psychotherapy or refuse it. While the decision-making ability of such troubled adolescents would seem to be immediately suspect, this may be the right group to be testing since it is individuals with such problems who actually might be asked to decide whether or not to accept treatment. However, while the study provides comparisons among younger and older adolescents up to 19 years of age, it does not provide a comparison between those with and those without such problems. In any event, participants ranging in age from 10 to 19 years of age showed no differences in distinguishing risks, benefits, and irrelevant considerations, or in the treatment decisions made.

In a similar study, Kaser-Boyd et al. [1985][37] compared participants aged 10-13 to those aged 14-20 in their ability to assess risks and benefits of psychological treatment. No differences were found in risk identification or on eight benefit dimensions.[38]

Lewis [1981][39] asked students aged 12-19 years of age what advice they would give peers who were faced with a variety of choices: cosmetic surgery, choice of custodial parent, a research trial involving acne medication, and research on "the mind." The participants fell into the following groupings: grades 7-8, grade 10 and grade 12. The study found no age-related differences in advice the participants said they would give regarding consultation with peers or parents, and the study found no differences in revisions of attitudes in the light of new information.

Ambuel [1989][40] collected data from 75 women, aged 13 to 21, who suspected an unplanned pregnancy and were visiting a medical clinic for a pregnancy test. The study gave the women a questionnaire to obtain demographic data to determine the women's knowledge about pregnancy, parenthood, adoption, and abortion, and to elicit information concerning relevant life experience, effects of the unplanned pregnancy and decision conflict. Ambuel then conducted a semi-structured interview concerning their pregnancy decision making which was tape recorded for later content analysis. This study is noteworthy for combining a real-world setting in which research participants faced a potentially serious and stressful decision with extensive and careful measurement of attitudes, affect and cognition. Analysis of the data revealed no age-related differences for three measures of cognitive competence (thoroughness of consideration of consequences, number of reasons considered, and quality of the process and content of reasoning about pregnancy) and a measure of "volitional competence,"--except for those women aged 13-15 who indicated they excluded abortion from among the alternatives they were considering as a response to an unwanted pregnancy.[41]

Belter & Grisso [1984][42] studied the ability of 60 males aged 9, 15, and 21 to recognize a violation of their rights in a simulated counseling session and to take steps to assert and protect their rights against violations by the professional. The research procedure involved half the participants at each age level receiving briefings (partially videotaped, partially live review) on the rights of patients.[43] In a subsequent session participants observed a videotaped counseling session, and were asked at various points whether or not a right was being violated, and if so, what they would do to protect the right. Their responses were measured and served as the experiment's dependent variables. Fifteen-year-olds did not differ from 21-year-olds in their recognition or protection scores, or in the benefit they gained from the briefing about rights.

2. Age Related Differences

Turning next to the differences among age groups which were found by the core studies, Lewis [1980][44] found that the adults in the pregnancy clinic were more likely to want to consult an independent professional and more likely to consider their own child-rearing abilities in deciding whether or not to have a child. Minors were more likely to consider the impact of their child on their own parents and gave more weight to the likelihood of possible deformity of their baby. Minors also tended to perceive the decision as being more externally determined than as being within their own power to make. (This may simply reflect their life experience in other domains.)

While Weithorn and Campbell [1982][45] found that groups aged 14, 18, and 21 showed no differences, the nine-year-olds did differ in many ways from the other groups. The nine-year-olds were more likely to select inpatient treatment for depression. Indeed, there was a systematic trend for younger participants to be more accepting of inpatient treatment and older participants to be more and more likely to reject it. The nine-year-olds also differed from the other groups in the reasons for the treatment choices they made, in factual understanding of the conditions, and in appreciation of consequences. The finding of differences between one of the groups in this study allays many of the methodological concerns previously discussed and makes the non-differences found take on added significance.

While Kaser-Boyd et al. [1986][46] found no differences as a function of age, Kaser-Boyd et al. [1985][47] report that older participants identified more potential benefits from psychotherapy and expressed the perceived benefits in more abstract terms. This provides an illustration of how the more commonsensical perception of differences between young adolescents and adults may be attributable to language use rather than a difference of decision-making capacity.

Lewis [1981][48] found that with increasing age there was an increasing tendency to mention risks, future consequences, and the desirability of consulting an independent specialist, i.e., one without vested interests in the choice made, and there was an increasing tendency to express caution about the advice of persons with vested interests in the choice made.

Ambuel [1989],[49] as noted in the previous subsection, found one important age-related difference. Minors aged 13-15 who did not consider abortion as an option, but no other groups of minors, categorized either by age or attitude toward abortion, had significantly lower scores than adults on every measure of competence except the number of reasons considered. This difference suggests that those who consider abortion as a possibility have cognitive and volitional competencies similar to or indistinguishable from legal adults, while those who are not as competent have ruled out the treatment and therefore are not likely to seek abortion anyway. If this were generally true, it would be a convenient matching of empirical phenomenon with legal need.

Belter & Grisso [1984][50] found that nine-year-olds showed significantly lower recognition of or asserted protection of rights than did the fifteen-year-olds or twenty-one-year-olds, who did not differ from each other.

B. Other Studies on the Age-Competence Relationship

Several studies, which are not part of the core group, provide some additional insight concerning age-related similarities and differences in health decision making.

Lewis et al. [1977][51] studied the behavior of children in an innovative program in two schools, which allowed children to make their own decisions as to whether they had a health problem requiring the attention of the school nurse. The children (aged 5-12) signed themselves out of class to see the nurse, the nurse examined the child, reported the findings to the child and informed the child about treatment options, and the child, not the nurse, selected the treatment option. In short, the children were allowed the same freedom as adults in making their own health care choices. This program was first carried out in a university elementary school at the University of California at Los Angeles and then replicated in a Los Angeles public school. The study found that those children made sensible (even in adult terms) use of their power to choose, and that the pattern of health service utilization by those children closely resembled that of adults, though no direct comparisons were or really could be made. Importantly, these children are below the age at which we would have any theoretical reason based upon Piagetian developmental psychology to expect equivalence between child and adult decision making. Note also that these choices had real consequences for treatment.

Lewis et al. [1978][52] invited 213 children who were 6-9 years of age, 85% white, middle to upper middle socio-economic status, grouped in their elementary school classrooms, to become informed about swine flu vaccine trials and to decide whether or not to volunteer to participate. If a child did volunteer, the consent of the child's parents was sought, and if granted, the child did participate in the vaccine trial. Thus, the child's decision had potential real consequences. The study found that very few age-related differences occurred in the elicitation by the children from the medical researchers of information about the flu and the vaccine and about potential risks and benefits of participation. The only differences were as follows: one class of six-year olds did not elicit all the relevant information it could have; older children were more likely to ask about the likelihood that swine flu would strike their community; and younger children were less likely than older children actually to volunteer to participate. Note that this study really measured group rather than individual ability to elicit information critical to making the decision to participate in medical research. The possibility--indeed, the likelihood--of wide variation in problem-solving ability within age groups suggests that this method of testing would tend to mask between-age-group differences. That is, assuming that the percentage of individuals who could think of all the questions to ask increased with age, then any of these groups might as groups be able to ask all the right questions and appear equally capable, while in fact important developmental changes were occurring over time (as larger and larger percentages of children in older classes would individually be able to ask the appropriate questions). The question before us focuses on individual competence and the information seeking of individuals that is more typical of the informed consent process in our institutions. Still, it is striking that even in a group of six-year-olds there are enough group members that in all but one class the full array of relevant information was elicited by the children.

Kazdin [1986][53] had parents and their severely disturbed children rate the acceptability of different kinds and settings of treatment. Parents rated both outpatient treatment and hospitalization as more acceptable than their children did. Parents rated hospitalization higher than out-patient treatment; their children rated them in the reverse order. For parents the strength of treatment was positively correlated with acceptability; for children it was negatively correlated. Kazdin suggests that the differences probably reflect differences in the meaning of the treatments for parents (e.g., relief) and children (e.g., abandonment).

Interview studies of children further confirm that understanding proceeds developmentally, and that the abilities necessary to make treatment decisions are acquired earlier than is often realized. During the period of cognitive development termed concrete operations by Piaget, around ages 7-11, children acquire the ability to accurately perceive professional help-givers and concepts of specificity and causality of explanations of healing and illness.[54]

An important note of caution is raised by a study that addresses not medical decision making by minors but legal decision making: Grisso's [1981][55] study of juveniles interrogated by police, with particular attention to the decision making of these youths in asserting or waiving their legal rights. The study reminds us that different contexts or different subsets of youth may show important differences compared with adult decision makers. For example, while 42% of arrested adults chose not to answer police questions, fewer than 10% of juveniles asserted their right to remain silent, and of those below age 15 virtually none refused to submit to police questions.[56] Grisso found that as a group, juveniles aged 14 and below had a sufficiently poor understanding of the Miranda[57] warnings that a decision to assert or waive those rights had little meaning.[58] And as many as half of those aged 15-16, whose IQs were below 80 or who were black or who were in lower socioeconomic groups,[59] also showed little comprehension of their legal rights and the consequences of asserting or waiving their rights. In addition, greater contact with juvenile courts and police was associated with improved understanding of Miranda rights among white juveniles, but poorer understanding among black juveniles. Greater contact with police and courts did, however, lead to greater understanding of the different roles of judges, lawyers, and police.[60] The important effects of these other variables suggest the need for policy-makers to consider them as well as age, and we now turn to studies involving these other variables in the context of health decision making by minors.

C. Effects of Other Variables

The studies already reviewed, as well as additional studies, contain findings on relevant variables other than age.

1. Gender

Weithorn and Campbell [1982][61] was the only core study that specifically examined effects of gender. This study used equal numbers of male and female participants and found no differences in decision making due to gender. Several of the studies included only males or only females, so comparisons between genders are not possible in those studies. The Lewis et al. [1977] study[62] concerning the use of health services by schoolchildren aged 5-12 reported that the sex ratio of utilization of health services in their study paralleled that of adult use, i.e., girls made more use of the school health services than boys. The Lewis et al. [1978] study[63] involving children aged 6-9 invited to volunteer for swine flu trials reported no differences between boys and girls in the questions asked, but boys volunteered less often than girls, and girls more often than boys found themselves unable to make a choice concerning volunteering.

2. Socioeconomic Status

Lewis et al. [1977][64] was the only study reviewed that explicitly compared different socio-economic status groups. The study found that less affluent students made more visits to the school health service. In addition, this study suggests that the more affluent children saw physicians as occupying a lesser role in health maintenance than the poorer children did. That is, the poorer children saw their health as more in the control of physicians; the affluent children saw their health as under the control of other forces, many of which were in their own hands. The other studies reviewed contain few minors from lower socio-economic strata, or not enough to conduct data analysis on, so it is not possible to say more about possible differences between children of different strata.

3. Ethnicity

Ethnicity is correlated to a considerable degree with socio-economic status in the nation at large, and presumably this correlation exists for the samples in the studies reviewed. Thus, findings of the studies with respect to socio-economic status probably have application to African-American and Hispanic children. In addition, Kaser-Boyd et al. [1986][65] report that Anglo subjects obtained higher scores on the decision vignettes with which study participants were tested. Finally, Lewis et al. [1977][66] reported that with increasing experience in their self-activated health program, white children increasingly saw themselves as the decision makers, but the same shift did not occur for the African-American or Hispanic children.

4. Intellectual Skills

Only one study, Kaser-Boyd et al. [1986][67], compared participants with different intelligence or a comparable measure of intellectual ability. This study found, unsurprisingly, that those with poor reading comprehension scored less well on the decision tasks. We have mentioned the existence of considerable intra-group variation in decision-making ability, and the possibility of that being accounted for by variables which may be more important to the quality of decision making than effects of age differences. Intelligence may well be that variable, but little data exist on this topic.

5. Experience

Kaser-Boyd et al. [1986][68] found that participants who were inexperienced with therapy obtained higher scores on the decision vignettes. Kaser-Boyd et al. [1985][69] found that participants who were experienced with therapy were more likely to assert that risks were low in psychotherapy, and that participants currently referred to therapy saw somewhat more benefits. No other studies of which we are aware make comparisons among experienced and inexperienced decision makers. One would expect decision makers experienced with the decision domain to show some differences from those who are new to the decision domain. Presumably, one advantage of older, especially considerably older, decision makers is experience with the decision task, and presumably some decisions benefit more from such experience than others.

6. Condition Severity

The only study to examine the effect of condition severity on competence to decide was Kaser-Boyd et al. [1986].[70] This study found that those not presently referred for psychological treatment and those with moderate rather than severe behavior problems scored higher on the treatment decision vignettes. Recall that all of the participants in this study were young people with moderate to severe learning or behavior problems, and it seems obvious that those with more serious problems will not do as well in making decisions as those whose problems are less severe. Another approach might be to ask if the severity of the condition makes a difference so long as it does not impair the decision maker's level of intellectual functioning. A partial answer is provided by the Weithorn and Campbell [1982][71] and Lewis [1981][72] studies that presented to participants several different treatment dilemmas varying in seriousness. These two studies reported no systematic differences as a function of the seriousness of the condition. Here is an issue in which the hypothetical versus real nature of the test situation may make an important difference. For example, one's decision making about a case of warts seems likely to be more unruffled than one's decision making about a serious form of cancer with no clear treatment preferences. The question then becomes whether these presumed differences show a statistical interaction with age, but no studies provide an answer to this question.

7. Social Influence

One issue that often is raised, but less often studied with care, is the ability of minors to make independent decisions not unduly influenced by peers, parents, or professionals. Unfortunately, this issue seems to fall between two subfields of psychology and as a result has been neglected by both. Developmental psychologists have shown little interest in conformity or social influence; social psychologists have not been interested in how conformity and social influence phenomena change as a function of development. The casual impression, of course, is that youngsters are more yielding and more dependent upon the judgments of others, especially peers, than adults are. But without appropriate comparative data, we cannot be sure that this is so. Young children are certainly less assertive, more conforming, and yielding to others, usually adults--apparently seeing choices, rights, and independence as something that exist only to the degree that adults bestow them.[73] Adolescents are stereotyped as both anti-conforming to adult preferences and over-conforming to peer preferences. But the obverse appears true of adults--tending to reject adolescent preferences and conforming to the preferences of their own peers. The comparisons, as always, must be to appropriate groups of adults because a belief that minors are too susceptible to social influence to make independent judgments must rest implicitly on a belief that adults are not similarly susceptible.

The little research we have found on the general relationship between age and yielding to social influence shows it to be a complex one. Studies show inconsistent findings, which may be reconciled by positing that conformity decreases from ages 7 to 11, then increases from 11-13, and then begins to decrease again.[74]

One study, Scherer and Reppucci [1988],[75] examines the effects of parental pressure on children's health decisions, but does not compare these children to a group of adults subjected to comparable pressure. This study involved the presentation of hypothetical treatment dilemmas to 40 children aged 14 and 15 who were asked if the person in the hypothetical situation ought to consent to suggested treatment options for tonsillitis, depression, enuresis, warts, or a request for kidney donation. Parental influence came in two forms: suggestive or blatant. The study found that with increased parental pressure, the adolescents' confidence in their preferred choice decreased. In short, they yielded greatly to parental pressure.[76] The more invasive and consequential the health problem and the treatment choices, the less the participants yielded to parental pressure. The more socially sensitive the condition, the more they yielded to parental pressure.

This issue has not, as far as we can tell, benefitted even from a thoughtful conceptual analysis of the questions that need to be asked. For example, it is not clear whether the expressed concern is about "normative social influence" rather than "informational influence,"[77] though presumably it is. Conformity in response to informational influence means going along with group preferences because one believes those preferences are a guide to the correct solution to a problem. Many professionals rely on other members of their profession, indeed, upon pronouncements of their professional associations, to guide them to precisely this kind of conformity. Normative social influence refers to group influence that is based not on the informational value of what other group members do, but instead on the desire to be accepted by the group by conforming to its beliefs and behavior. Is the concern about yielding to social influence that minors, more than adults, will refrain from treatment at their peers' behest? Or seek treatment at their peers' behest? Or be too submissive to professional advice? Or not submissive enough? When is a rejection of information from and about others evidence of independent judgment and when is it a sign of irrationality? When is sensitivity to the ideas and conduct of others thoughtful open-mindedness and when is it conformity? Does the tendency to comply vary with the context? For example, when minors become ill and are cut off from their peers, the peer group preferences probably cease to have any importance or effect. But the question of differential conformity remains for those minors whose conditions exist in the midst of, and even are conditioned by, their everyday social relationships (drugs, alcohol, pregnancy, for example).

Surely the amount of conformity varies widely with the social situation as well as with the patient. Compare, for example, the high proportion of cases in which patients do not comply with medical advice concerning patient-administered medication (which has averaged 50-60% in most studies and has gone as high as 92%)[78] with the high degree of consent to submit to whatever in-patient procedures are being proposed.[79] A setting constructed in an effective way, and without doing anything the law would regard as coercive, can make virtually any target of social influence do almost anything.[80] Medical practitioners, as well as students of the physician-patient relationship[81], are aware of the fluctuation in patient compliance and its relationship to the situation in which compliance is sought.

The implication of these social influence phenomena in health care delivery for the present discussion are as follows: Developmental effects may be overshadowed by situational variables. If virtually all adults can be made to consent to any treatment, then it borders on the impossible for adolescents to be more susceptible to such influences. The notion that adults are "independent" minded while adolescents are submissive or wavering may well be nothing more than a cultural stereotype unsupported by data. It may still be that the answer is a more complex situation-by-development interaction. If so, studies will need to be done to examine that possibility. And, as noted above, the answer to the issue of conformity may be highly dependent upon the kind of health problem and the setting of the treatment.

8. Skill Training

Recall that in the Belter & Grisso [1984][82] study half the participants at each age level received briefings on patient rights and half did not. This amounts to specific training in one aspect of decision making by patients. Unsurprisingly, those who received briefings showed significantly higher recognition and protection scores than those who did not. This was not true, however, for the 9-year-olds, who did not benefit from the briefing. Even though the youngest group was able to paraphrase their rights at the time of learning, they did not retain them or understand them in a way they could retrieve them later, or in any event later show an ability to recognize the violations of rights, or to take steps to challenge the violation. By contrast, both the 15-year-olds and the 21-year-olds derived significant benefit from the briefing. Without the briefing, 21-year-olds showed a higher level of rights recognition and protection than the 15-year-olds, presumably due to the greater exposure to these issues that occurred with their increased age. But with the briefings the 15-year-olds and the 21-year-olds performed indistinguishably in the recognition and protection of their rights as patients.

All of the other studies already discussed involved no special efforts to teach decision-making skills to minors. Some additional research has addressed the question of whether decision-making skills can be taught. For example, Weinstein [1988][83] has prepared children for psychotherapy by using videotaped modeling, and Hammes & Petersen (1986)[84] have shown that sixth grade children can be taught resistance to persuasion and thereby become able to make more independent decisions. These studies suggest that even if minors were found to lack adult-level competence to consent,[85] it might be possible to prepare them to make decisions that reflect a heightened level of competence.

While this hardly seems surprising, it is a neglected possibility when minors' competence is discussed.

SECTION THREE
IMPLICATIONS OF EMPIRICAL STUDIES FOR PUBLIC POLICY FORMULATION

Are the empirical studies specifically reviewed sufficient to establish that adolescents as a group, aged fourteen or fifteen and above, are competent to consent to their own health care? Although the studies that form the core of our review are not great in number, they show considerable consistency in their findings, and those findings are consistent with a huge body of research on cognitive development generally.[86]

At the same time, it is recognized that while formal operational thought (the last stage of cognitive development in the Piagetian system) appears in most minors by around age fourteen, for some it appears sooner, for others later, and for still others never. Moreover, the notion of systematic, orderly stages is in some doubt, and the exact circumstances of the task and context affect whether formal operational thought is or is not employed by the minor.[87]

While empirical studies specifically reviewed focus on health care decision-making tasks and compare minors of various ages with adults, the studies, taken as a whole, still leave gaps in the knowledge ideally needed for policy formulation concerning the health care decision-making capacities of minors. Few of the studies examine performance in situations sufficiently real and stressful to see what effects such situations may have on decision-making performance, although the studies that did examine this found the same pattern of results as the others. None of the studies compared minors with much older adults, although the likelihood is that the inclusion of much older adults would have improved the apparent performance of minors. Additional uncertainties include the general lack of data concerning the effects of socioeconomic status, ethnicity, social influence, skill training, and experience, and how these might interact with the age-competence relationship found in the generally white middle-class groups studied. It is difficult to know how well one may generalize from the groups studied to the groups not studied.

Two basic responses can be made to those problems. One is to carry out studies designed to generate more complete data. The other is to make judgments as to whether the pattern of findings of existing studies is firm enough to expect them to carry over into untested areas.

What can be said with some confidence is that the findings of the empirical studies reviewed, at a minimum, provide no support for the assumption that minors, especially adolescent minors fourteen years of age and older, as compared to adults, lack the capacity to make health care decisions. Hence, these studies challenge the traditional and implicit assumption of the law that adolescents are unable to make these health care decisions as well as adults.

It does not necessarily follow, however, that these studies dictate the conclusion that a legal presumption that adolescent minors fourteen years of age and older are competent to make health care decisions should be adopted. There is still the problem of individual variation in decision-making capacity within this age group.[88] Some members of this age group may not, in fact, have the requisite capacity to make health care decisions. Even if the average minor of any given age group can make health care decisions as well as the average adult, if the variability is much greater among the minors than it is among adults, that would mean that a large absolute number of minors might fall below whatever the standard of competence is. Some of the existing studies note the great variation of performance within age groups, but do not examine the problem beyond that.

This problem of individual variation can be dealt with by requiring individualized determinations of competency by courts or even by health professionals. But this approach gives rise to still another set of problems. Individualized determinations open the door to discriminatory and arbitrary determinations unless there are tests of decision-making capacity that are reliable and valid and that can be administered easily, and it is doubtful that there are such tests.[89] Moreover, individualized determination can be quite expensive. Still another way of dealing with the problem of individual variation is to establish a rebuttable presumption based on chronological age that can be used by courts to make individualized determinations of competence.[90] To illustrate, there could be a presumption that any minor fourteen years of age or older is competent to make health care decisions, but that presumption could be rebutted by evidence of an individual child's inability to make health care decisions.[91]

Finally, it must be emphasized that the health care decision-making capacity of minors has not been the sole determinant of the degree of freedom minors have been granted with respect to access to health services. The presumption that minors are incompetent regarding health care decision making stemming from assumptions about their lack of health care decision-making capacity is only one of several rationales, albeit a major rationale, for parental consent and notification requirements.[92] Similarly, a rejection of this legal presumption and these empirical assumptions is only one of several reasons for the recognized exceptions to these requirements.[93] In short, the capacity of a minor to make health care decisions may be a necessary but not a sufficient condition for allowing a minor to obtain health services on his or her own. Conversely, the lack of capacity on the part of a minor to make health care decisions may not preclude allowing the minor to obtain health services on his or her own.

CONCLUSION
A FRAMEWORK FOR PUBLIC POLICY FORMULATION

This background paper began by asking how the law should allocate authority for decision making regarding health care for an adolescent among the adolescent, the adolescent's parents, health professionals and the State. In the preceding pages, how the current law, consisting of statutes, judicial decisions, and administrative regulations, has allocated authority for adolescent health care decision making has been described.

Laws relating to the provision of health services to minors, including adolescents, have historically been the province of state governments rather than the federal government. Public policies allocating authority for health care decision making as to adolescents most often have been formulated by state legislatures, and they sometimes have been formulated by state courts and administrative agencies. In recent years, the United States Supreme Court and lower federal courts have begun to assume a role in allocating adolescent health care decision making through their power to interpret the provisions of the United States Constitution. The United States Supreme Court has specifically acted as the final arbiter of what is constitutionally permissible when it comes to state imposed restrictions, including parental consent and notification requirements, on the provision of family planning services and abortion services to minors.

While the source of laws governing the provision of health services to minors is at the present time primarily statutes promulgated by state legislatures, the United States Congress, if it so chooses, can play a role in the formulation of public policies allocating adolescent health care decision-making authority. Thus, Congress could, in theory, enact federal legislation which would have the effect of establishing particular substantive policies in this regard at the state and local level.

One option of Congress would be to enact legislation conditioning the receipt of federal funding for health services by states on their having statutes or administrative rules and regulations incorporating particular substantive policies with respect to health care decision making for and by adolescents. However, Congress thus far has not chosen to adopt this approach.

Another option of Congress simply would be to enact legislation requiring federal and federal/state programs providing health services for adolescents or providing reimbursement for health services furnished to minors to adopt particular substantive policies with respect to the allocation of adolescent health care decision making. There are a variety of federal and federal/state programs providing adolescent health services or providing reimbursement for adolescent health services that are authorized by Congress and for which Congress appropriates federal funds.

Among these programs are the Title XIX Medical Assistance (Medicaid) Program, the Title V Maternal and Child Health Services Block Grant Programs, the Title X Family Planning Program and the Alcohol and Drug Abuse and Mental Health Block Grant Programs. The legislation which authorizes and appropriates funds for these programs, and the regulations and rules which have been issued by the federal agencies administering these programs, for the most part, do not specify whether minors must have parental consent for their program participation, whether parents must be notified of their participation, or whether health care records and communications between program service providers and minors are confidential vis-a-vis their parents.[1] In the absence of explicit congressional or administrative agency directives, federal and federal/state programs have been free to enunciate their own policies regarding parental consent and notification and confidentiality of records and communications involving minors within the parameters imposed by state law and federal constitutional law.

If Congress were to assume a greater role in allocating adolescent health care decision making through its power to enact federal legislation, the current diversity of state laws concerning matters such as parental consent and notification would presumably be replaced with more uniform federal laws. Accordingly, one's position as to whether Congress should legislate in this area may be a function of the value attached to uniformity as opposed to diversity in the laws governing these and similar matters. One's position may also be a function of one's view as to what substantive policies with respect to these matters Congress, as opposed to state legislatures, is likely to adopt. The probability, at least in the near future, would seem to be that state legislatures rather than Congress will be the primary sources of laws relating to the allocation of adolescent decision-making authority.

However, regardless of the precise source of laws--state statutes, state court decisions, state administrative regulations, federal statutes, federal court decisions, federal administrative regulations--there remains the question of what legal rules regarding allocation of authority for adolescent health care decision making should be adopted. Despite the fact that this issue has been much debated, existing laws do not furnish clear and consistent answers to this issue. These laws currently differ widely from state to state and these laws often differ within a particular state in ways that do not appear to be coherent.

Public policy makers--legislators, judges, administrators of public programs--have the ultimate responsibility for resolving the issue of how the law should allocate authority for adolescent health care decision making. If public policy formulated in response to this issue is to be rational and appropriate, a framework for its analysis that is rational and appropriate must be established. Such a framework can be supplied through an analysis of the interests of the concerned actors in adolescent health care decision making, namely, the adolescent, the adolescent's parents, health professionals and the State.[2] Since the aim of such an "interest" analysis is to formulate public policy, the central issue becomes does the State have an interest or interests derived from the interests of the adolescent, the adolescent's parents or health professionals, or does the State have an independent interest or interests that would justify a particular allocation of authority for adolescent health care decision making through the vehicle of statutes, judicial decisions or administrative regulations.

The adolescent has an obvious interest in the preservation of his or her life and the achievement and maintenance of good physical and mental health, and this interest in life and health translates in to an interest on the part of the adolescent in ready and timely access to needed health services. The State, under its parens patriae power, clearly has an interest in protecting the life and health of the adolescent, and therefore, has an interest in assuring the adolescent's access to needed health services.

The nature and extent of the adolescent's interest, and by extension the State's interest, in access to health services varies. At one end of the spectrum are health services, such as emergency medical services for a seriously injured adolescent or mental health services for a suicidal adolescent, that are needed to preserve life. At the other end of spectrum are services, such as cosmetic surgery, that may be viewed as desirable but are not necessary to preserve or even to achieve or maintain health. In situations where the adolescent's life or health may be at stake the adolescent's interest and the State's interest in assuring access to health services should be paramount in any balancing of interests to arrive at an allocation of the authority to make decisions concerning the provision of health services to adolescents.

Given the adolescent's interest and the State's interest in assuring that the adolescent has access to needed health services, it becomes pertinent to inquire whether and to what degree legally mandated parental involvement through either parental consent requirements or parental notification requirements create barriers to access. As it has been pointed out, some support for the position that legal requirements for parental involvement create barriers to access to services and to utilization of services is to be found in several empirical studies concerning the impact of such requirements on the utilization of family planning and abortion services, but the applicability of the findings of the studies to other types of services is unclear.[3]

Granting that the adolescent and the State have an interest in assuring that the adolescent has access to needed services, a central concern becomes the competency of adolescents to make appropriate determinations as to their need for services in an appropriate manner. As has already been observed, there is increasing acceptance of the position that a presumption based solely on chronological age, that all adolescent minors, at least minors in middle and late adolescence, are incompetent to engage in health care decision making is not valid.[4] Nevertheless, a presumption that all minors in late and middle adolescence are competent does not take account of the variation that exists in decision-making capacity within this group.[5] The solution would seem to be individualized determinations of actual decision-making capacities, but this approach presents problems previously discussed.[6]

As regards the interests of the adolescents' parents, the parents may have several interrelated interests. Since affectional and familial ties often exist between parents and their minor children, parents may have an interest in assuring that decisions as to the provision of health services to the adolescent will be beneficial for the adolescent. However, it cannot necessarily be assumed that there is an identity of interest between an adolescent and his or her parents, or that an adolescent's parents will always act in the adolescent's best interest when it comes to health care decision making for the adolescent.

In view of the fact that parents are given the responsibility for the care, support and rearing of their minor children, the parents may also have an interest in the maintenance of their authority over the adolescent and may have a more generalized interest in the protection of their family's autonomy and privacy and the promotion of their family's stability and cohesiveness. The State may or may not have an interest in reenforcement of parental authority. The State certainly has an interest in the parents continuing to assume responsibility for the adolescent, and if their authority over the adolescent is reduced, they may be less willing to assume this authority. The State also has an interest in family autonomy and privacy, which are widely held values in this society, but family autonomy and privacy cannot necessarily be equated with reenforcement of parental authority. Similarly, the State is widely viewed as having an interest in family cohesiveness and stability, but family cohesiveness and stability cannot necessarily be equated with reenforcement of parental authority.

Health professionals also have interests that are often not discussed or even mentioned. One interest that health professionals have is an interest in the provision of services to adolescents that are consistent with their professional ethics and consistent with accepted professional practice.[7] Another interest of health professionals is a more narrow but nonetheless significant interest in clear and consistent laws to enable them to avoid unintentional violation of these laws. Moreover, health professionals have an interest in being able to receive compensation for services provided. However, it is not clear whether or to what degree the state has an interest in promoting or furthering these interests of health providers.

It has been observed that the State's interest or interests may be derived from and substantially the same as those of the adolescent, the adolescent's parents and health professionals. Frequently overlooked is the fact that the State may have interests independent from these actors. For example, the State under its police power clearly has an independent interest in assuring that adolescents are tested and treated for sexually transmitted diseases to prevent the spread of these diseases and thereby protect its citizens from them. The State also arguably may have an independent interest in assuring that the adolescent has access to family planning services and abortion services to the extent that adolescent child bearing results in increased public expenditures for health and human service programs that serve families started when the parents were adolescents and to the extent that adolescent childbearing is associated with negative health, educational, economic and social consequences for these families.[8]

The interests of the adolescent, the adolescent's parents, health professionals and the State may well differ depending on the type of services involved, and the way these interests are balanced may well differ depending on the type of services involved. Therefore, as a result of the suggested "interest analysis," the allocation of adolescent health care decision-making authority may vary in accordance with the type of services involved. For example, the product of such analysis may be one set of rules for general medical care, another set of rules for family planning services, and still another set of rules for substance abuse treatment and counseling.

Although it will not be an easy task for public policy makers to balance the interests of the adolescent's parents, health professionals and the State in order to allocate adolescent health care decision-making authority among these actors, identifying with precision the interests of the actors involved will hopefully result in clearer and more consistent policies as well as more rational and more appropriate policies. Yet it must be borne in mind that the formulation of public policy is ultimately done in a political environment and that public policy makers in formulating these policies must ultimately rely on value judgments about which there is no consensus.

ENDNOTES

PART ONE

PARENTAL INVOLVEMENT IN ADOLESCENT HEALTH CARE DECISION MAKING: EXISTING LAWS

NOTES

1. For a summary of the legal disabilities of minors see Clark, H.H., Jr., The Law of Domestic Relations in the United States 309-322, 2nd edition (St. Paul, Minn.: West Publishing Co., 1988). For a summary of restrictions on the liberty of minors including but not limited to medical treatment, see Dodson, G.D., "Legal Rights of Adolescents: Restrictions on Liberty, Emancipation, and Statute Offenses," Legal Rights of Children, 114-142, R.M. Horowitz and H.A. Davidson (eds.) (Colorado Springs, Colo.: Shepard's/McGraw-Hill, 1984).

2. See generally Wardle, L.D., Blakesley C.L. and Parker, J.Y. Contemporary Family Law; Principles, Policy and Practice, 1.01-1.09 (Deerfield, Ill.: Callaghan, 1988).

3. See e.g., Bonner v. Moran, 75 App. D.C. 156, 126 F.2d 121, 123 (D.C. Cir. 1941); Zoski v. Gaines, 271 Mich. 1, 260 N.W. 99 (1935); Moss v. Rishworth, Tex. Com. App., 222 S.W. 225 (1920); Rogers v. Sells, 178 Okla. 103, 61 P.2d 1018 (1936); Browning v. Hoffman, 90 W. Va 568, 111 S.E. 492 (1922), See Institute of Judicial Administration and American Bar Association, Juvenile Justice Standards Project, Standards Relating to Rights of Minors (Cambridge, Mass.: Ballinger Pub. Co., 1980) at 51 (hereafter cited as IJA-ABA Standards); Dodson, G.D. supra n. 1 at 136-137; Bennett, R., "Allocation of Child Medical Care Decision-Making Authority: A Suggested Interest Analysis," Va L. Rev. 62: 285-330, 1976.

4. ALASKA STAT. § 25.20.010 (1983); ARIZ. REV. STAT. ANN. § 1-215 (1989); ARK. CODE ANN. § 9-25-101 (1987); CAL. CIV. CODE § 25.1 (West 1982); COLO. REV. STAT. § 13-22-101 (1987); CONN. GEN. STAT. § 1-1d (1987); DEL. CODE ANN. tit. 1, § 707 (1985); D.C. CODE ANN. § 30-401 (1988); FLA. STAT. § 743.07 (1987); GA. CODE ANN. §39-1-1 (1982); HAW. REV. STAT. § 577-1 (1988); IDAHO CODE § 32-101 (1983); ILL. REV. STAT. ch. 110, para. 11-1 (1987); IND. CODE § 16-8-1-4 (1988); IOWA CODE § 599.1 (Supp. 1989); KAN. STAT. ANN. § 38-101 (1986); KY. REV. STAT. ANN. § 2-015 (Baldwin 1989); LA. CIV. CODE ANN. art. 29 (West Supp. 1989); ME. REV. STAT. ANN. tit. 1 § 72 (1989); MD. ANN. CODE art. 1 § 24 (1987); MASS. GEN. L. ch. 231, § 85P (1986); MICH. COMP. LAWS § 722.1 (1979); MINN. STAT. §§ 645.451, 645.452 (1988); MISS. CODE ANN. § § 41-41-5(a), 93-19-13 (1981); MO. REV. STAT. § 431.055 (1986); MONT. CODE ANN. § 41-1-101 (1989); NEV. REV. STAT. § 129.010 (1987); N.H. REV. STAT. ANN. § 21:44 (1988); N.J. REV. STAT. ANN. § 9:17B (West Supp. 1989); N.M. STAT. ANN. § 28-6-1 (1987); N.Y. PUB. HEALTH LAW § 2504 (McKinney 1988); N.C. GEN. STAT. § 48A-2 (1984); N.D. CENT. CODE

§ 14-10-01 (1971); OHIO REV. CODE ANN. § 3109.01 (Anderson 1989); OKLA. STAT. tit. 15, § 13 (1981); OR. REV. STAT. ANN. § 109.510 (1983); PA. STAT. ANN. tit. 16, § 2175(a) (Purdon Supp. 1988); R.I.GEN LAWS § 15-12-1 (1981); S.C. CODE ANN. § 20-7-30 (Law. Co-op. 1983); S.D. CODIFIED LAWS ANN. § 26-1-1 (1984); TENN. CODE ANN. § 1-3-105 (1985); TEX. FAM. CODE ANN. § 11.01 (Vernon Supp. 1989); UTAH CODE ANN. § 15-2-1 (1986); VT. STAT. ANN. tit. 1, § 173 (1985); VA. CODE ANN. § 1-13.42 (1987); WASH. REV. CODE §§ 26.28.010 to 26.28.020 (1987); W. VA. CODE § 2-2-10(a) (1987); WIS. STAT. § 48.02(1) (1985-86).

5. ALA. CODE § 26-1-1 (1986); NEB. REV. STAT. § 43-2201 (1988); WYO. STAT. § 8-1-102(a) (1986).

6. ALA. CODE § 22-8-4 (1984); KAN. STAT. ANN. § 38-123b (1986); R.I. GEN LAWS § 23-4. 6-1 (1985); S.C. CODE ANN. § 20-7-280 (Law. Co-op. 1985); OR. REV. STAT. § 109.640 (1981).

7. See text infra, 36-38 and accompanying notes.

8. The law of torts protects persons against unauthorized bodily invasion, and bodily contact with a patient by a physician or surgeon without the patient's consent constitutes the a technical battery, which is a tort. However, today the tort of negligence has largely replaced the tort of battery as the specific basis for liability for failure to obtain informed consent. See Keeton, W.P., Dobbs, D.B., Keeton, R.E., and Owen, D.G. (eds.), Prosser and Keeton on the Law of Torts 5th ed. (St. Paul, Minn.: West Publishing Co., 1984).

9. See e.g., Gillette v. Tucher, 67 Ohio St. 106, 65 N.E. 865 (1902); Rolater v. Strain, 39 Okla 572, 137 P. 96 (1913) Dodson, G.D., supra n.1 at 137; Wilkins, L.P., "Children's Rights: Removing the Parental Consent Barrier to Medical Treatment of Minors," Ariz. S. L.J. 1975(1) 31-93, 1975.

10. In dealing with issues of consent to health care for minors state courts and lower federal courts have consistently expressed concern about the decision-making capabilities of minors. For example, in Bonner v. Moran, 75 App. D.C. 156, 126 F.2d 121, 122 (1941) the court stated: "In deference to common experience, there is general recognition of the fact that many persons by reason of their youth are incapable of intelligent decisions, as a result of which public policy demands legal protection of their personal as well as their property rights."

In recent years the United States Supreme Court, in dealing with issues concerning access of minors to contraceptives and abortions and the civil commitment of minors, has similarly expressed concern about the decision-making capabilities of minors. See e.g. Parham v. J.R., 442 U.S. 584, 602, 603 (1978) ("The law's concept of the family rests on a presumption that parents possess what a child lacks in maturity, experience, and capacity for judgment required for many of life's difficult decisions.") ("Most children, even in adolescence, simply are not able to make sound decisions, including their need for medical care or treatment"); Bellotti v. Baird, 443 U.S. 622, 633, 640 (1978), reh. denied, 444 U.S. 887 (1979) ("[T]he Court has held that the state validly may limit the freedom of children to choose for themselves in the making of important, affirmative choices with potentially serious consequences. These rulings have been grounded in the recognition that, during the formative years of childhood and adolescence, minors often lack the experience, perspective and judgment to recognize and avoid choices that could be detrimental to them."); ("[P]arental notice and consent are qualifications that typically may be imposed by the state on a minor's right to make important decisions. As immature minors often lack the ability to make fully informed choices that take account of both immediate and long-range consequences, a state reasonably may determine that parental consultation often is desirable and in the best interest of the minor."); Planned Parenthood of Missouri v. Danforth, 428 U.S. 52, 91 (1976) (Stewart, J., concurring) ("That [the abortion decision] is a grave decision, and a girl of tender years under emotional stress, may be ill-equipped to make it without mature advice and emotional support."); Planned Parenthood of Missouri v. Danforth, supra at 102 (Stevens, J., concurring in part and dissenting in part) ("The State's interests in the welfare of its young citizens justifies a variety of protective measures. Because he may not foresee the consequences of his decisions, a minor may not make an enforceable bargain. * * * But even if it [the abortion decision] is the most important kind of a decision a young person may ever make, the assumption merely enhances the quality of the State's interest in maximizing the probability that a decision be made correctly and with full understanding of the consequences of either alternative. * * * A legislative determination that such a choice will be made more wisely in most cases if the advice and moral support of a parent play a part in the decision-making process is surely not irrational.") Carey v. Population Services International, 431 U.S. 678, 709 (1977), (Powell, J. concurring) ("The State justifiably may take note of the psychological pressures that might influence children at a time in their lives when they generally do not possess the maturity necessary to understand and control their responses."); Carey v. Population Services International, supra at 714 (1977) (Stevens, J. concurring) ("The states' important interest in the welfare of its young citizens justifies a number of protective measures. [citation omitted] Such special legislation is premised on the fact that young persons frequently make unwise choices with harmful consequences.")

11. See Wardle, L.D., Blakesley, C.L. and Parker, J.Y. supra n. 2 at 1.

12. Id. at 1-15.

13. Harvard Law Review, "Developments in the Law--The Constitution and the Family," *Harv. L. Rev.* 93:1156-1383, 1980 (hereafter cited as *Developments in the Law*).

14. *Id.* at 1218.

15. Holder, A.R. "Disclosure and Consent in Pediatrics," *Law, Med. & Health Care* 16(3-4):219-228, 1988.

16. See Horowitz, R.M. "Children's Rights: A Look Backward and a Glance Ahead," *Legal Rights of Children*, *supra* n. 1 at 1-9; see also *infra*, note 18.

17. Beginning over fifty years ago the Supreme Court has held that parents have a federal constitutional right to direct the upbringing of their children free from state intervention in the absence of a constitutionally acceptable justification for such intervention. The Court's most notable decisions in this regard are *Meyer v. Nebraska,* 262 U.S. 390 (1923); *Pierce v. Society of Sisters,* 268 U.S. 510 (1925); *Prince v. Massachusetts,* 321 U.S. 158 (1944); and *Wisconsin v. Yoder* 406 U.S. 205 (1972). In *Meyer v. Nebraska,* the Court stated that "[due process] denotes . . . the right of the individual . . . to marry, establish a home and bring up children" and then declared that a state statute prohibiting the teaching of foreign languages in the schools was unconstitutional in part because it "interfere[d] with the power of parents to control the education of their own." 262 U.S. at 399, 401. In *Pierce v. Society of Sisters* the Court subsequently held that the "liberty of parents and guardians to direct the upbringing and education of children under their control" encompassed the right to send their children to private and parochial schools and struck down as unconstitutional a state statute requiring every child to attend public schools. 268 U.S. at 534.

In *Prince v. Massachusetts,* the Court interpreted *Meyer* and *Prince* as recognizing a "private realm of family life which the states cannot enter" without a compelling reason and said that "the custody, care and nurture of a child reside first in the parents whose primary function and freedom include preparation for obligations the state can neither supply nor hinder." 321 U.S. at 158. The Court sustained the constitutionality of a criminal conviction of a Jehovah's Witness, in her capacity of aunt and guardian of a child for permitting the child to sell religious literature in violation of child labor laws and arrived at this result by balancing the parental interests against the states' interests at issue and found that the latter outweighed the former. In *Wisconsin v. Yoder,* the Court held that Amish parents could not be compelled to send their children beyond the eighth grade. The Court stressed that "the value of parental direction of the religious upbringing and education of the children in their early and formative years have a high place in our society." 406 U.S. at 213-14. The Court noted that a state's interest in "universal education ... is not totally free from a balancing process when it infringes on fundamental rights and interests, such as those specifically protected by the Free Exercise Clause of the First Amendment, and the traditional interests of parents with respect to the religious upbringing of their children, so long as they, in the words of Pierce, 'prepare [them] for additional obligations.'" 406 U.S. at 214. See also Ginsburg v. New York 390 U.S. 629, 634 (1968), reh. denied, 391 U.S. 971 (1973) ("Constitutional interpretation has consistently recognized that the parents' claim to authority in their own household to direct the rearing of their children is basic to the structure of our society.")

In another line of decisions the Supreme Court afforded minors some of the same constitutional rights that adults are afforded with respect to areas that do not directly implicate the right of parents to direct the upbringing of their children. See, e.g., In re Gault, 387 U.S. 1 (1967); Tinker v. Des Moines Independent Community School District, 393 U.S. 503 (1969); Goss v. Lopez, 419 U.S., 565 (1975).

In recent years the Supreme Court has begun to confront conflicts between a parent's asserted right to direct the upbringing of his or her minor child and the minor's assertion of his or her own independent rights. Thus, the Supreme Court has issued decisions involving actual or potential parent-child conflicts with respect to the access of minors to contraceptives and abortions and the civil commitment of minors. However, the results and rationales of the decisions, taken as a whole, do not reflect a coherent approach to such conflicts. See infra, pp. 21-25, 31, 34-37.

18. Clark, H.H., Jr., supra n. 1 at 258-66.

19. IJA-ABA STANDARDS, supra n. 3 at 61; Mnookin, R.H. Child, Family and State, Problems and Materials on Children and the Law (Boston, Mass.: Little, Brown, 1978). A related but nonetheless distinct problem is that a parent has a responsibility to support and maintain a minor child in the event that medical treatment or surgery is unsuccessful and results in ongoing medical expenses for care even if the parent did not consent to the medical treatment or surgery. See Lacey v. Baird, 166 Ohio St. 12, 139 N.E. 2d 25, 30 (1956).

20. See IJA-ABA Standards, supra n. 3 at 61.

21. Morrisey, J.M., Hofmann, A.D. and Thrope, J.C., Consent and Confidentiality in the Health Care of Children and Adolescents, A Legal Guide (New York, N.Y.: Macmillan, 1986) contains a state-by-state table of state laws pertaining to consent to health services for minors, but this table is now out of date.

22. "Developments in the Law," supra n. 13 at 1199. See Addington v. Texas, 441 U.S. 418, 426 (1979); O'Conner v. Donaldson, 422 U.S. 563, 583-84 (1975). The United States Supreme Court (Burger, C.J.

concurring) has characterized the parens patriae doctrine as follows:

> "[I]ts meaning is murky and its historic credentials are of dubious relevance. The phrase was taken from chancey practice where, however, it was used to describe the power of the state to act in loco parentis for the purpose of protecting the property interests and the person of the child." In re Gault, 38 U.S. 1, 16 (1967).

23. ALA. CODE § 26-14-1 (1986); ALASKA STAT. § 47-10.010(a)(2)(B) (Supp. 1989); ARIZ. REV. STAT. ANN. § 13-3620(A) (1989); ARK. CODE ANN. § 9-27-303(4)(B) (Supp. 1989); CAL. PENAL CODE § 11165.2(b) (West Supp. 1989); COLO. REV. STAT. § 19-1-103(20)(d) (1986); CONN. GEN. STAT. § 46b-120(iv) (1989); DEL. CODE ANN. tit. 31, § 301(3) (1985); D.C. CODE ANN. § 16-2301(24) (1989); FLA. STAT. § 39.01(37) (1989); HAW. REV. STAT. § 350-1(4) (1988); IDAHO CODE 16-1602(n)(1) (Supp. 1989); ILL. REV. STAT. ch. 37, 802-3 (1987); IND. CODE ANN. § 31-6-4-3(a)(1) (1988); IOWA CODE § 232.2(6)(e) (Supp. 1989); KAN. STAT. ANN. § 38-1502(b) (1986); KY. REV. STAT. § 600.020(1) (1989); LA. REV. STAT. ANN. § 14:403(B)(5) (West Supp. 1989); ME. REV. STAT. ANN. tit. 22, § 4002(6)(B) (Supp. 1988); MD. FAM. LAW CODE § 5-701(n)(2) (Supp. 1988); MICH. COMP. LAWS ANN. § 722.622(c) (West 1981); MINN. STAT. § 626.556(2)(c) (1988); MISS. CODE ANN. § 43-21-105(1)(i) (Supp. 1988); MO. REV. STAT. § 210.110(5) (1986); MONT. CODE ANN. § 41-3-102(3)(c) (1987); NEV. REV. STAT. § 432B.140 (1987); N.J. REV. STAT. § 9:6-8.21(c)(4) (Supp. 1989); N.M. STAT. ANN. § 32-1-3(L)(2) (Supp 1989); N.Y. SOC. SERV. LAW § 371.(4-a) (McKinney 1983); N.C. GEN. STAT. § 7A-517(21) (Supp. 1988); OHIO REV. CODE ANN. § 2151.03(c) (Anderson 1976); OKLA. STAT. ANN. tit. 21, § 852 (West Supp. 1988); OR. REV. STAT. § 418.740(1)(e) (1987); R.I. GEN. LAWS § 40-11-2(2)(d) (Supp. 1988); S.C. CODE ANN. § 20-7-409(c)(3) (Law Co-op. 1983); S.D. CODIFIED LAWS ANN. § 26-8-6(4) (1984); TENN. CODE ANN. § 37-1-102(10)(D) (Supp. 1988); TEX. FAM. CODE ANN. § 34.012(2)(ii) (Vernon Supp. 1989); VT. STAT. ANN. tit. 33, § 682(3)(c) (Supp. 1988); VA. CODE ANN. § 63.1-248.2(A)(2) (1987); W. VA. CODE § 49-1-3(g)(1)(A) (1986); WIS. STAT. § 48.981(1)(d) (1985-86); WYO. STAT. § 14-6-201(a)(xvi)(A) (Supp. 1988).

24. GA. CODE ANN. § 15-11-2(8)(A) (Supp. 1988); MASS. GEN. L. ch. 119, § 24 (1986); N.H. REV. STAT. ANN. § 169-C:3 (xix) (b) (Supp. 1988); PA. STAT. ANN. tit. 11, § 2203 (Purdon Supp. 1988); UTAH CODE ANN. § 62A-4-502(4) (Supp. 1988); WASH. REV. CODE § 26.44.020(12) (1987).

25. See, e.g., People ex rel. Wallace v. Labrenz, 411 Ill. 618, 104 N.E. 2d 769 (1952), cert. denied 399 U.S. 829 (1952).

26. See, e.g., In re Hudson, 13 Wash.2d. 673, 126 P.2d 765 (1942); In re Seiferth, 309 N.Y. 80, 127 N.E.2d 820 (1955).

27. Bennett, R., supra n. 3 at 302-303. However, there are a few cases where courts have considered the opinions of an adolescent minor relevant but not controlling. See, e.g., In re Green, 448 Pa. 338, 292 A.2d 387 (1972).

28. Clark, H.H., Jr., supra n. 1 at 322.

29. For an excellent discussion of the origins and development of emancipation see Clark, H.H., supra note 1 at 322-28; IJA-ABA Standards, supra n.3 at 20-33; Cady, F., "Emancipation of Minors," Conn. L. Rev. 12:62-91, 1979; Katz, S., Schroeder W., and Sidman, L., "Emancipating Our Children--Coming of Age in Legal America," Fam. L. Q. 7:211-230, 1973.

30. One leading commentary on emancipation has summarized these factors as follows:

> Only marriage and enlistment in the armed services are generally deemed sufficient in themselves to constitute emancipation.
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> * * *
>
> Absent marriage or enlistment determinations of emancipation are made by evaluating all of the surrounding circumstances on a case by case basis.
>
> * * *
>
> Among the most frequently considered factors are: whether the child is living at home, whether the child is paying room and board if living at home, whether the parents are exercising disciplinary control over the minor, whether the child is independently employed, whether the child has been given the right to retain wages and spend them without parental restraints, whether the child is responsible for debts incurred and the extent of the parents' contributions toward the payment of outstanding bills, whether the child owns a major commodity such as a car, and whether the parent has listed the child as a dependent for tax purposes. Age, of course, is also a critical factor.

Katz, S., Schroeder, W. & Sidman, L., supra n.25 at 217-18 (footnotes omitted).

31. ALA. CODE §§ 26-13-1 to 26-13-8 (1986); ALASKA STAT. § 09.55.590 (1983 & Supp. 1989); ARK. CODE ANN. § 9-26-104 (1987 & Supp. 1989); ILL. REV. STAT. ch. 40, para. 2201 to 2211 (1987 & Supp. 1988); KAN. STAT. ANN. §§ 38-108 to 38-110 (1986); LA. CIV. CODE ANN. art. 385 (West Supp. 1989); ME. REV. STAT. ANN. tit. 15 § 3506-A (Supp. 1989); OR. REV. STAT. §§ 109.510 to 109.565 (1983); TENN. CODE ANN. §§ 29-31-101 to 29-31-105 (1980); W. VA. CODE § 49-7-27 (1986).

32. CAL. CIV. CODE §§ 62-69 (West 1982); CONN. GEN. STAT. §§ 46b-150 to 46b-150e (1987); MONT. CODE § 41-3-408 (1989); NEV. REV. STAT. §§ 129.080 to 129.140 (1987); N.M. STAT. ANN. §§ 28-6-3 to 28-6-8 (1987); VA. CODE ANN. §§ 16.1-331 to 16.1-334 (1988); WYO. STAT. §§ 14-1-101(b)(v), 14-1-201 to 14-1-206 (Supp. 1989).

33. LA. CIV. CODE ANN. arts. 366, 368 to 384 (West. 1982 & Supp. 1989); MICH. COMP. LAWS § 722.4 (West 1989); PA. STAT. ANN. tit. 16, § 2175(6) (Purdon 1989); S.D. CODIFIED LAWS ANN. §§ 25-5-17 to 25-5-23 (1984 & Supp. 1989).

34. MICH. COMP. LAWS § 722.4 (West 1989) (When minor is in the custody of a law enforcement agency and his or her parent cannot be promptly located, the minor is considered emancipated for purposes of consenting to routine, nonsurgical medical care or emergency medical care).

35. ARIZ. REV. STAT. ANN. § 44-132 (1987); ARK. CODE AN. § 20-9-602(6) (1987); IND. CODE § 16-8-12-2 (1988); KY. REV. STAT. ANN. § 214.185(3) (Baldwin Supp. 1989); MISS. CODE ANN. § 41-41-3 (Supp. 1988); MONT. CODE § 1-1-402 (1989); N.M. STAT. ANN. § 24-10-1 (1986); N.C. GEN. STAT. § 90-21.5(b) (1985); OKLA. STAT. tit. 63, § 2602(1) (1981).

36. ALA. CODE § 22-8-5 (1984) (minor who has borne a child may consent to any legally authorized medical, dental, health or mental health services for self and child); ALASKA STAT. § 09.65.100(3) (1983) (minor who is the parent of a child may consent to medical and dental services for self and child); ARK. CODE ANN. § 20-9-602(2) (1987) (minor parent may consent for any medical or surgical treatment or procedure not prohibited by law for his child, but illegitimate father cannot consent for children solely on the basis of parenthood); COLO. REV. STAT. 13-22-103(3) (1987) (minor parent may consent to hospital, medical, dental, emergency health and surgical care for his/her child); CONN. GEN. STAT. § 19a-285 (1989) (minor who has borne a child may consent to medical, dental, health and hospital services for his/her child); DEL. CODE ANN. tit. 13, § 707(a)(4) (1981) (minor may consent for his child for any medical, surgical, dental or osteopathic practitioner or hospital or clinic to perform diagnostic, therapeutic, or postmortem procedures and any hospitalization or other necessary care in connection therewith); FLA. STAT. § 743.065(2) (1987) (unwed minor mother may consent to medical or surgical care or services for her child by hospital, clinic or physician); GA. CODE ANN. § 31-9-2 (1985) (minor parent may give consent to any surgical or medical treatment or procedure not prohibited by law for his minor child); IDAHO CODE § 39-4303 (1985) (consent for furnishing of hospital, medical, dental or surgical care, treatment or procedures to any person who is not then capable of giving such consent as provided in this act or who is a minor or incompetent person, may be given or refused by any competent parent, spouse or guardian unless the patient is a competent adult who refused to give consent); ILL.

REV. STAT. ch. 111, para. 4502 (1987) (a parent who is a minor may consent to performance of medical or surgical or dental procedure upon his child); KAN. STAT. ANN. § 38-122 (1986) (minor parent may consent for his/her child to the performance of medical, surgical or post mortem procedure by a physician); KY. REV. STAT. ANN. § 214.185(3) (Baldwin Supp. 1989) (minor who has borne a child may consent to hospital, medical, dental or surgical care to his/her child or himself); LA. REV. STAT. ANN. § 40:1299.53(b) (West 1977) (minor parent may for his child give consent for any medical or surgical treatment or procedures, including autopsy, not prohibited by law); MD. HEALTH-GEN. CODE ANN. § 20-102(a)(2) (1982) (minor parent has the same capacity as an adult to consent to medical treatment); MASS. GEN. L. ch. 112, § 12F (1988) (minor parent may give consent to medical or dental care for himself/herself and child); MINN. STAT. § 144.342 (1988) (minor who has borne a child may consent to medical, dental, mental and other health services for self and child); MISS. CODE ANN. § 41-41-3 (Supp. 1988) (minor parent may consent for his child for any medical or surgical procedures or treatments not prohibited by law; however, father of illegitimate child cannot consent for child solely on basis of parenthood); MO. REV. STAT. § 431.061(3) (1986) (minor parent or legal custodian of a child may consent to any medical or surgical procedures or treatment not prohibited by law for himself, his child and any child in his legal custody); MONT. CODE ANN. § 41-1-402(2) (1989) (minor who has had a child may consent to health services for the child); NEV. REV. STAT. § 129.030 (1987) (a mother who has borne a child may consent for self and child to any examination and treatment, except sterilization, by a hospital, clinic, or physician, provided she understands the nature and purpose of the treatment, its probable outcome, and voluntarily requests it); N.J. STAT. ANN. § 9:17A-1 (West 1976) (married or pregnant minor may consent for self and children for medical and surgical care or procedures); N.Y. PUB. HEALTH LAW § 2504(2) (McKinney 1985) (parent of a child may consent to medical, dental, health and hospital services for himself and child); OKLA. STAT. tit. 63, § 2602(A)(1),(4) (1981) (minor who has a dependent child may consent to health services for self and child); PA. STAT. ANN. tit. 35, §§ 10101, 10102 (Purdon 1977) (minor who has been pregnant, borne a child or married may consent for self and child); R.I. GEN. LAWS § 23-4.6-1 (1989) (minor parent may consent to treatment for his or her child); S.C. CODE ANN. § 20-7-300 (Law. Co-op. 1985) (minor who has been married or borne a child may consent to health services for the child); S.C. CODE ANN. § 20-7-270 (Law. Co-op. 1985) (married minor may consent for self and child for any diagnostic, surgical, therapeutic or postmortem procedures by medical, surgical or dental practitioner); UTAH CODE ANN. § 78-14-5(4)(a) (1987) (minor parent may consent to any health care not prohibited by law for his child).

37. ALA. CODE §§ 22-8-4 to 22-8-5 (1984) (minor who is married, or is divorced, may consent to medical, dental, health or mental health services); ARIZ. REV. STAT. ANN. § 44-132 (1987) (married

minor may consent to hospital, medical and surgical care and subsequent annulment or divorce shall not result in deprivation of adult status for this purpose); ARK. CODE ANN. § 20-9-602(3) (1987) (married minor may consent to surgical and medical treatment or procedures); CAL. CIV. CODE § 25.6 (West 1982) (minor who is or has been married may consent to hospital, medical, dental, emergency health, and surgical care); COLO. REV. STAT. § 13-22-103 (1987) (married minor may consent to any hospital, medical, dental, emergency health, and surgical care); GA. CODE ANN. § 31-9-2 (1985) (married minor may consent to any surgical or medical treatment or procedures not prohibited by law); ILL. REV. STAT. ch. 111, para. 4501 (1987) (married minor may consent to performance of medical or surgical procedures by a physician); IND. CODE § 16-8-12-2(2)(C) (1988) (minor who is or has been married may consent to his/her own health care); KY. REV. STAT. ANN. § 214.185(4) (Baldwin Supp. 1989) (married minor may consent to hospital, medical, dental or surgical care for himself, and a subsequent annulment or divorce does not result in deprivation of adult status for this purpose); LA. REV. STAT. ANN. § 40: 1299.53(c) (1977) (married minor may consent to any medical or surgical treatment or procedures, including autopsy, not prohibited by law); MD. HEALTH-GEN. CODE ANN. § 20-102(a)(1) (1982) (married minor has same capacity as adult to consent to medical treatment); MASS. GEN. L. ch. 112, § 12F (1988) (minor who is married, widowed, divorced can consent to medical or dental care); MINN. STAT. § 144.342 (1988) (minor who has been married may consent to medical, mental, dental and other health services); MISS. CODE ANN. § 41-41-3 (Supp. 1988) (married minor may consent to medical or surgical procedures or treatments not prohibited by law); MO. REV. STAT. § 431.061(3) (1986) (married minor may consent to any medical or surgical treatment or procedures not prohibited by law); MONT. CODE ANN. § 41-1-402(a) (1989) (minor who is or ever was married may consent to medical or surgical care or services by hospital, clinic or physician); NEV. REV. STAT. § 129.030 (1987) (married minor or minor who has been married may consent to examination and treatment, other than sterilization, provided by physician, hospital, board of health, or health officer, as long as he understands the nature and purpose of treatment, its probable outcome and voluntarily requests it); N.M. STAT. ANN. § 24-10-1 (1986) (married minor may consent to hospital, medical and surgical care, and subsequent annulment or divorce does not result in deprivation of adult status for this purpose); N.Y. PUBLIC HEALTH LAW § 2504 (McKinney 1985) (any person who has married may consent to hospital, medical, dental and health services); OKLA. STAT. tit. 63, § 2602 (1981) (married minor may consent to health services); PA. STAT. ANN. tit. 35, § 10101 (Purdon 1977) (any married person may consent to medical, dental and health services); R.I. GEN. LAWS § 23-4.6-1 (1989) (any married person may consent to routine emergency medical or surgical care); S.C. CODE ANN. § 20-7-270 (Law. Co-op. 1985) (married minor may consent to any lawful diagnostic, therapeutic, surgical or postmortem procedures by medical, surgical or dental practitioners); VA. CODE ANN. § 54.1-2969(E) (1988) (married minor may consent to any surgical and medical treatment except for sexual sterilization); WYO. STAT. § 14-1-101 (1986) (minor who is or was married may consent to health care treatment to the same extent as an adult).

38. ALASKA STAT. § 09.65.100(a)(1) (1983) (minor who is living apart from parents or legal guardian and managing his own financial affairs, regardless of the source or extent of income, may consent to medical and dental services); CAL. CIV. CODE § 34.6 (West 1982) (minor 15 years old or over who is living apart and separate from parents or guardian, regardless of duration, is managing his own financial affairs, regardless of source, may consent to hospital care or any x-ray examination, anesthetic, or medical, dental or surgical diagnosis or treatment); COLO. REV. STAT. § 13-22-103 (1987) (minor 15 years of age or older who is living separate and apart from his parent/guardian, with or without the consent of parent/guardian, and managing his own financial affairs, regardless of source of income, may consent to hospital, medical, dental, emergency health, and surgical care); IND. CODE § 16-8-12-2(2)(B) (1988) (minor at least 14 years old who is not dependent on a parent for support, is living apart from his parents or individuals in loco parentis, and is managing his own affairs may consent to his own health care); MASS. GEN. L. ch. 112, § 12F (1988) (minor who is living separate and apart from parents/guardian, and is managing his own financial affairs may consent to medical or dental care); MINN. STAT. § 144.341 (1988) (minor living separate and apart from parents/guardian, with or without their consent, regardless of the duration, and who is managing personal financial affairs, regardless of source or extent of income, may consent to medical, dental , mental or other health services); MONT. CODE ANN § 41-1-402(1)(b) (1989) (minor who has been separated from his parent, parents, or legal guardian for whatever reason and is supporting himself by whatever means may consent to medical or surgical care or services from a hospital, clinic or physician); NEV. REV. STAT. § 129.030 (1987) (minor living apart from parents/guardian, with or without their consent, and has so lived for at least 4 months, may consent, for self and child, to any examination and treatment, except sterilization, provided he understands the nature and purpose of exam/treatment and its probable outcome and voluntarily requests it); OKLA. STAT. tit. 63, § 2602(A)(2) (1981) (minor who is separated from his parents/guardian for whatever reason and is not supported by them may consent to health services); TEX. FAM. CODE § 35.03 (Vernon 1986 & Supp. 1989) (minor who is 16, resides separate and apart from parents/guardian, with or without their consent, regardless of duration, and is managing his own financial affairs, regardless of source of income, may consent to hospital, medical, surgical and dental care); WYO. STAT. § 14-1-101(b)(iv), (v) (1986 & Supp. 1989) (minor who is living apart from parent/guardian and is managing his own affairs regardless of income may consent to health care treatment to the same extent as an adult).

39. CAL. CIV. CODE § 25.7 (West 1982) (minor on active duty with armed services may consent to hospital, medical and surgical care); IND. CODE § 16-08-12-2(2)(D) (1988) (minor in the military service may consent to his own health care); MASS. GEN. L. ch. 112, § 12F (1988) (minor who is a member of armed forces may consent to medical or dental care); TEX. FAM. CODE ANN. § 35.03 (Vernon 1986 & Supp. 1989) (minor on active duty in armed forces may consent to hospital, medical, surgical and dental care); WYO. STAT. § 14-1-101 (1986 & Supp. 1989) (minor in active military service may consent to health care treatment to the same extent as an adult).

40. ALA. CODE § 22-8-4 (1984) (minor who has graduated from high school may consent to any legally authorized medical, dental, health or mental health services); MONT. CODE ANN. § 41-1-402(1)(a) (1989) (minor who has graduated from high school may consent to medical or surgical treatment or care provided by a hospital, clinic or physicians); PA. STAT. ANN. tit. 35, § 10101 (Purdon 1977) (minor who has graduated from high school may consent to medical, dental and health services).

41. IJA-ABA Standards, _supra_ n. 3 at 65.

42. _Bakker v. Welch,_ 155 Mich. 632, 108 N.W. 94 (1906).

43. See, e.g., _Younts v. St. Francis Hospital,_ 205 Kan. 292, 469 P.2d 330 (1970); _Bishop v. Shurley,_ 237 Mich. 76, 211 N.W. 75 (1926); _Gulf & Ship Island R.R. v. Sullivan,_ 155 Miss. 1, 119 So. 501 (1929); _Lacey v. Laird,_ 166 Ohio St. 12, 139 N.E.2d 25 (1956). See also, American Law Institute, _Restatement of the Law (Second) of Torts_, Vol. 4 (St. Paul, Minn.: American Law Institute Publishers, 1979) (§ 892A(b) of the Restatement provides for purposes of the law of torts that if person consenting is a child, consent may still be effective if child is capable of appreciating the nature, extent and probable consequences of conduct consented to).

44. Rothenberg, K.H. "Medical Decision Making for Children," _BioLaw_ J. Childress and R. Gaare (eds.) (Frederick, MD.: University Publications of America, 1986). This authority has further stated that additional factors to be considered in making a mature minor determination are:

> (1) the minor can initiate and keep his own medical appointments and has come by himself, (2) he appears to be motivated to cooperate with treatment, and (3) the opinion of another doctor supports the findings. _Id._

45. See text _infra_ at 16-17 and accompanying notes.

46. ARK. CODE ANN. § 20-9-602(7) (1987) (Any unemancipated minor of sufficient intelligence to understand and appreciate the consequences of the proposed surgical or medical treatment or

procedures may consent); MISS. CODE ANN. § 41-41-3(h) (Supp. 1988) (Any unemancipated minor of sufficient intelligence to understand and appreciate the consequences of the proposed surgical or medical treatment or procedures may consent for himself); N.H. REV. STAT. ANN. § 318-B:12a (1984) ("nothing contained herein shall be construed to mean that any minor of sound mind is legally incapable of consenting to medical treatment provided that such minor is of sufficient maturity to understand the nature of such treatment and the consequences thereof").

47. IDAHO CODE § 39-4302 (1985); NEV. REV. STAT. § 129.030(2) (1987). But see, NEV. REV. STAT. § 129.030(1) (1987).

48. See Keeton, W., supra n. 8.

49. See, e.g., Wells v. McGenee, 39 So.2d 196 (La. App. 1949); Jackovach v. Yocom, 212 Iowa 914, 237 N.W. 444 (1931); Luka v. Lourie, 171 Mich. 122, 136 N.W. 1106 (1912).

50. ALA. CODE § 22-8-3 (1984) (medical, dental, health or mental health services may be rendered to minors of any age without the parental consent when, in the physician's judgement, an attempt to secure consent would result in delay of treatment which would increase the risk to the minor's life, health or mental health); ARIZ. REV. STAT. ANN. § 36-2271(C) (1986) (when it has been determined by a physician that an emergency exists and that it is necessary to perform such surgical procedures for the treatment of a serious disease, injury or drug abuse, or to save the life of a patient, or when such parent or legal guardian cannot be located or contacted, care may be provided without parental consent); ARK. CODE ANN. § 20-9-603(1) (1987) (Consent will be implied when an emergency exists and there is no one immediately available who is authorized to consent); DEL. CODE ANN. tit. 13, § 707(a)(5) (1981) (Minor may consent after reasonable efforts are made to obtain parental consent for the examination and treatment of any laceration, fracture or other traumatic injury suffered by such minor, or any symptom, disease or pathology which may, in the judgement of the attending personnel preparing such treatment, if untreated, reasonably be expected to threaten the health or life of such minor); FLA. STAT. ANN. § 743-064 (1987) (physician may render emergency medical care or treatment without parental consent to any minor who has been injured in an accident or who is suffering from an acute illness, disease, or condition if delay in initiation of medical care or treatment would endanger the health of the minor); GA. CODE ANN. §§ 31-9-2, 31-9-3 (1985) (consent will be implied for treatment of a minor where, according to competent medical judgement, the proposed surgical or medical treatment or procedures are reasonably necessary and delay in treatment could reasonably be expected to jeopardize the life or health of the person affected or could reasonably result in disfigurement or impaired faculties); ILL. REV. STAT. ch. 111, para. 4503 (1987) (where a hospital or a physician renders emergency treatment or

first aid or a dentist renders emergency dental treatment to minor, consent of the minor's parents or guardian need not be obtained if, in the sole opinion of the physician, dentist or hospital, the obtaining of consent is not reasonably feasible under the circumstances without adversely affecting the condition of the minor's health); IOWA CODE § 147A.10 (1989) (physician, physician's designee, advanced EMT or paramedic shall not be subject to civil liability solely by reason of failure to obtain consent before rendering emergency medical, surgical, hospital or health services to any individual, regardless of age, when patient is unable to give consent for any reason); KAN. STAT. ANN. § 65-2891 (1987) (health care provider who in good faith renders emergency care or assistance at the scene of an emergency or accident including treatment of a minor without first obtaining the consent of the parent or guardian shall not be liable in rendering such emergency care); KY. REV. STAT. ANN. § 214.185(3) (Baldwin Supp. 1989) (medical, dental and other health services may be rendered to minors of any age without parental consent when, in the professional's judgement, the risk of the minor's life or health is of such a nature that treatment should be given without delay and the requirement of consent would result in delay or denial of treatment); MD. HEALTH-GEN. CODE ANN. §20-102(b) (1982) (a minor has the same capacity as an adult to consent to medical treatment if, in the judgement of the attending physician, the life or health of the minor would be affected adversely by delaying treatment to obtain the consent of another individual); MASS. GEN. L. ch. 112, § 12F (1988) (physician, dentist or hospital shall be liable for damages for failure to obtain consent of minor's parent/guardian to emergency examination and treatment, including blood transfusions, when delay would endanger minor's life, limb or mental well-being); MINN. STAT. § 144.344 (1988) (medical, dental, mental and other health services may be rendered to minors of any age without parental consent when, in the professional's judgement, the risk to the minor's life or health is of such a nature that treatment should be given without delay and the requirement of consent would result in delay or denial of treatment); MO. REV. STAT. § 537.037 (1986) (physician or surgeon, nurse or emergency medical technician who in good faith renders emergency medical care or assistance, without compensation, to any minor involved in an accident, or in competitive sports, or other emergency, at the scene of the accident, without first obtaining parental consent, shall not be liable); MONT. CODE. ANN. § 41-1-402(1)(d) (1989) (minor who needs emergency care, including transfusions, without which his health will be jeopardized may consent to medical or surgical care); MONT. CODE ANN. § 41-1-405(1) (1989) (health care professional may render emergency service of first aid, medical, surgical, or psychiatric treatment, without compensation, to any person regardless of age who is in need of immediate health care when the professional believes that the giving of aid is only alternative to probable death or severe physical or mental damage); MONT. CODE ANN. § 41-1-405(2) (1989) (health professional may render non-emergency services to minors for conditions which will endanger the health or life of the minor if the services would be delayed by obtaining consent of spouse, parent, parents, or legal guardian); NEB. REV. STAT. §71-5512 (1986) (emergency medical technician, physician, physician surrogate, or certified field supervisor shall be liable based solely upon failure to obtain consent in rendering emergency medical, surgical, hospital, or health services to any individual regardless of age when the patient is unable to give his or her consent and no person authorized to consent is reasonably available); N.Y. PUB. HEALTH LAW § 2504(4) (McKinney 1985) (medical, dental, health and hospital services may be rendered to persons of any age without the consent of a parent or legal guardian when, in the physician's judgement, an emergency exists and the person is in immediate need of medical attention and an attempt to secure consent would result in delay of treatment which would increase the risk to the person's life or health); N.D. CENT. CODE § 14-10-17.1 (1981) (minor may contract for and receive emergency examination, care, or treatment in a life threatening situation); OKLA. STAT. tit. 63, §2602(a)(7) (1981) (minor may consent to emergency services for conditions which would endanger his life or health if delay would result from obtaining consent from his spouse, parent or legal guardian); OKLA. STAT. tit. 63, § 2604 (1981) (where emergency care is needed and the minor is unable to give consent, a parent, spouse or legal guardian may authorize consent); PA. STAT. ANN. tit. 35, §10104 (Purdon 1977) (medical, dental and health services may be rendered to minors of any age without parental consent when, in the physician's judgement, an attempt to secure consent would result in delay of treatment which would increase the risk to the minor's life or health); R.I. GEN. LAWS § 23-4.6-1 (1989) (person age sixteen (16) or over or married may consent to routine emergency medical or surgical care); S.C. CODE ANN. § 20-7-290 (Law. Co-op. 1984) (Health services of any kind may be rendered to minors of any age without parental consent when, in the judgment of a provider of health service, such services are deemed necessary but an operation shall be performed only if it is essential to the health or life of a minor child, in the opinion of performing physician and a consultant physician if one is available); S.D. CODIFIED LAWS ANN. § 20-9-4.2 (1987) (minor may be treated by a physician without parental consent if a parent is not immediately available and if, in the opinion of the practicing physician, the attempt to secure consent would result in delay of treatment which would threaten the minor's life or health); S.D. CODIFIED LAWS ANN. § 20-9-4.2 (1987) (no physician, hospital or other person assisting in the treatment of a minor may be held liable for providing medical or surgical treatment without parental consent of the minor's life or health would be threatened by delaying treatment); TENN. CODE ANN. § 63-6-222(a) (1986) (licensed physician may perform emergency medical or surgical treatment on a minor despite absence of parental consent if delay in rendering emergency care would result in a serious threat to the life of the minor or a serious worsening of such minor's medical condition, and such emergency treatment is necessary to save the minor's life or prevent further deterioration of his condition); TENN. CODE ANN. § 63-6-222(c) (1986) (physician rendering emergency care to a minor shall not be liable); VA. CODE ANN. § 54-1-2969(C) (1988) (minor fourteen or older must consent, if physically able, before emergency medical or surgical treatment is rendered without parental consent); VA. CODE ANN. § 54-1-2969(C) (1988) (whenever delay in providing medical or surgical treatment to a minor may adversely affect such minor's recovery and no person authorized to consent to such treatment for such minor is available within a reasonable time, no liability shall be imposed by reason of lack of consent to such medical or surgical treatment); WYO. STAT. ANN. § 14-1-101(b)(iii) (1988) (minor may consent to health care treatment if the parents or guardian of the minor cannot with reasonable diligence be located and the minor's need for health care treatment is sufficiently urgent to require immediate attention).

51. See n. 50, supra.

52. 381 U.S. 479 (1965).

53. 405 U.S. 438 (1972).

54. 431 U.S. 678 (1977).

55. Id. at 693, quoting Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976).

56. ALASKA STAT. § 09.65.100(a)(4) (1983) (minor may consent for services for prevention of pregnancy); ARK. CODE ANN. § 20-16-304 (1987) (medically acceptable contraceptive procedures, supplies and information shall be available to every person regardless of age); CAL. CIV. CODE § 34.5 (West 1989) (unmarried minor may consent to hospital, medical, surgical care related to the prevention or treatment of pregnancy); COLO. REV. STAT. § 13-22-105 (1987) (birth control procedures, supplies and information may be furnished by a physician to a minor who requests and is in need of such services, is referred for such services by a physician and other designated individuals and agencies or who is pregnant, a parent or married); DEL. CODE ANN. tit. 13, § 708 (1981) (minor over 12 who professes to be exposed to chance of becoming pregnant may consent to preventative procedures (except abortion)); FLA. STAT. § 381.382(5) (1987) (maternal health and contraceptive information may be furnished minor by physician or state health agency, family planning program if minor may suffer probable health hazards in the absence of such services or minor is married, a parent or pregnant); GA. CODE ANN. § 31-9-2(a)(5) (1988) (minor may consent to treatment for pregnancy or prevention thereof); HAW. REV. STAT. § 577A-2 (1988) (minor who is seeking family planning services may consent to the provision of medical care and services by public and private hospitals and clinics or the performance of medical care and services by a physician); IDAHO CODE § 18-603 (1987) (physician or health care provider may provide examinations, prescriptions,

devices and materials regarding prevention of contraception to any person he finds "sufficiently intelligent and mature to understand the nature and significance thereof"); ILL. REV. STAT. ch. 111 1/2, para. 4651 (1987) (contraceptive services and information may be furnished by physician to any minor who is married, a parent, pregnant, has parental consent, or who is referred by a physician, clergyman, planned parenthood agency, or to whom the failure to provide such services would create a serious health hazard); KAN. STAT. ANN. § 23-501 (1988) (contraceptive information methods, means and devices may be furnished by state family planning centers to any person who is over 18 and married or who is referred by physician who resides in the state); KY. REV. STAT. ANN. § 214.185 (Baldwin Supp. 1989) (minor may consent to contraception services); ME. REV. STAT. ANN. tit. 22, § 1908 (1980) (physician may provide family planning services to any minor who is a parent, married, has parental consent or if in physician's opinion may suffer probable health hazards if services are not provided); MD. HEALTH-GEN. CODE ANN. § 20-102 (1982) (minor may consent to treatment for or advice about contraception other than sterilization); MISS. CODE ANN. § 41-42-7 (1981) (contraceptive supplies and information may be furnished by physician to a minor who is a parent, married, has consent of parent, or who has been referred by physician, clergyman, family planning clinic, school, institution or agency of the state); N.M. STAT. ANN. §§ 24-8-3, 24-8-5 (1986) (the purpose of the Family Planning Act is to assure family planning services are accessible on a "voluntary basis to all who want and need them." No person shall be subject to any standard or requirement as a prerequisite to services except requirement of referral to a physician, payment for service, or requirement imposed by law or regulation); N.Y. SOC. SERV. LAW §§ 465 to 473 (McKinney Supp 1989) (Adolescent Pregnancy Prevention Programs include provisions of family planning services to adolescents under 18 who are at risk of becoming a parent, are pregnant, or are parents); N.C. GEN. STAT. § 90-21.5 (1985 & Supp. 1989) (minor may consent to medical health services for the prevention of pregnancy, excluding abortion and sterilization); TENN. CODE ANN. § 68-34-107 (1985) (physician may furnish contraceptive supplies to any minor who requests and is in need of birth control procedures, supplies or information; or any minor who is pregnant, a parent, married, has parental consent or has been referred by another physician, clergyman, family planning clinic, school or state agency); UTAH CODE ANN. § 76-7-322 (Supp. 1989) (no public funds shall be used to provide contraceptive services to unemancipated unmarried minors not in the armed forces. "Parental consent requirements while not per se in conflict with federal law, impermissively engrafted an eligibility requirement on Medicaid services in violation of Title XIX of Soc. Sec. Act and Utah's participation in the Medicaid program brings into play a conflict with federal law which renders section unenforceable" (Planned Parenthood Ass'n v. Danday, 635 F. Supp. 184 (D. Utah 1986) Trial court properly enjoined state's future refusal to reimburse providers for family planning services, including contraceptives, "given to minors in the absence of proof of parental consent, since the state must make reimbursements required by federal law as long as it participates in Medicaid." Planned Parenthood v. Danday, 810 F.2d 984 (10th Cir. 1987)); VA. CODE ANN. § 54.1-2969(d) (eff. 7/1/90) (minor may consent to medical or health services required in case of birth control, pregnancy or family planning except for sterilization); WYO. STAT. § 42-5-101 (1988) (family planning and birth control information and services provided by State agency to any person who may benefit from these services).

57. There is an extensive body of law regarding sterilization with a distinction being made between voluntary sterilization, which refers to sterilization as a means of birth control, and involuntary sterilization as a eugenic measure designed to prevent the mentally incompetent from procreating. In most states sterilization of minors is prohibited or quite restricted. See Wardle, L.D., Blakesley C.L. and Parker, J.Y., supra n. 2 at §§ 6:03-6:04. See also Haavin, S.F. and Menniger, K.A., Sexuality Law and the Developmentally Disabled Person (Baltimore, MD.: P.H. Brookes Pub. Co., 1981).

58. See text infra at 16-18 and accompanying notes.

59. See, supra n. 64.

60. 410 U.S. 113 (1973).

61. The Court stated that some state abortion regulation might be permissible to promote its legitimate interests in safeguarding a woman's health, in maintaining proper medical standards and in protecting human life. The Court held that during the first trimester the state may require only that the abortion be performed by a licensed physician, that after the first trimester, the state may "regulate the abortion procedure in ways that are reasonably related to maternal health," and that once the fetus is "viable," the state may "regulate, even proscribe, abortion except where it is necessary in appropriate medical judgment, for the preservation of life or health of the mother." 410 U.S. at 164-65.

62. In Planned Parenthood of Missouri v. Danforth, 428 U.S. 52 (1976) the Court struck down as unconstitutional a provision of a state statute that required immature minors to obtain the consent of a parent or person in loco parentis prior to an abortion during the first trimester of pregnancy because it gave a minor's parents an absolute veto over the minor's abortion. The Court stated that minors have constitutional rights, including the right to an abortion, albeit the state has broader authority to regulate the activities of minors than of adults with the test to be applied in the case of minors "whether there was a significant state interest in conditioning an abortion on the consent of a parent." Id. at 76.

In Bellotti v. Baird (Bellotti II) 443 U.S. 622 (1979) the Supreme Court held unconstitutional a state statute requiring an unmarried minor to obtain the consent of both parents prior to abortion but providing that, if one or both parents refused, an abortion could be obtained pursuant to court order upon good cause being shown. Four justices concluded that the statute, as written and construed by the state courts, was unconstitutional because it required parental consultation or notification for every non-emergency abortion unless no parent was available without regard to whether consultation or notification was in her best interest and did not afford her an opportunity to obtain independent judicial consent upon a showing that either she was mature enough to consent or an abortion would be in her best interest. Four other justices concluded that the statute, as written and construed by the state courts, was unconstitutional because under the statute, even a mature minor capable of making an informed decision may not obtain an abortion without parental consent or judicial consent, thereby making the minor's abortion decision subject to an absolute third-party veto.

In *City of Akron v. Akron Center for Reproductive Health, Inc.,* 462 U.S. 416 (1973) the Court overturned as unconstitutional a provision of a city ordinance that required parental consent as a prerequisite for abortion of a minor of fifteen years or an order from a court having jurisdiction over the minor. The Court found that the ordinance did not explicitly create an alternative procedure to parental consent for obtaining authorization for an abortion that met constitutional requirements on the ground that it was not clear that a state juvenile court would have authority to hear abortion requests or to inquire into the minor's maturity.

In *Planned Parenthood Association v. Ashcroft,* 462 U.S. 476 (1983) the Court upheld the constitutionality of a state statute requiring that minors obtain parental consent or judicial consent to an abortion. The Court concluded that the statute provided "an alternative to parental consent in the form of a juvenile court proceeding that satisfied constitutional requirements." In light of the fact that the statute had been interpreted to mean that the court cannot deny a minor' application for consent to an abortion "for good cause" unless the court first finds that the minor was not mature enough to make her own decision.

63. ALA. CODE §§ 26-21-3, 26-21-4 (Supp. 1989) (parental consent and judicial bypass); ALASKA STAT. § 18.16.010(a)(3) (1986) (parental consent, no bypass provisions) (unconstitutional per opinion of attorney general, Oct. 1976); ARIZ. REV. STAT. ANN. § 36-2152 (Supp. 1989) (parental consent and judicial bypass) (enjoined in *Roe v. Collins,* No. 85-2118 PHX CLH (D. Ariz. Aug. 14, 1987); CAL. HEALTH & SAFETY CODE § 25958 (West Supp. 1989) (parental consent and judicial bypass but injunction lifted Feb 13, 1989); COLO. REV. STAT. § 18-6-101 (1986) (parental consent, no bypass provision) (language concerning parental consent held unconstitutional in *Foe v. Vanderhoof,* 389 F.Supp. 947 (1975)); DEL. CODE ANN. tit., 24, § 1790(b)(3) (1987) (parental consent, no bypass provisions); FLA. STAT. ANN. § 390-001(4)(A) (West 1986) (written parental consent and judicial bypass); IND. CODE § 35-1-

58.5-2.5 (1986) (parental consent and judicial bypass); KY. REV. STAT. ANN. § 311.732 (Baldwin Supp. 1988) (parental consent and judicial bypass); LA. REV. STAT. ANN. § 40:1299.35.5 (West Supp. 1989) (parental consent and judicial bypass) (See: Cage v. Wood, 484 So.2d 850 (App. 1 Cir. 1986) (abortion constitutes battery if physician, who knew legal requirements for parental consent, failed to get notarized consent from parents and accepted consent form written by another person). MASS. GEN. L. ch. 112, § 12S (1988) (parental consent and judicial bypass); MISS. CODE ANN. §§ 41-41-53, 41-41-55 (Supp. 1988) (parental consent and judicial bypass) (enjoined in Barnes v. Mississippi, No. J86-0458(w) (S.D.Miss., filed July 24, 1986)); MO. REV. STAT. § 188.028 (1986) (parental consent and judicial bypass) (held constitutional in T.L.J. v. Webster, 792 F.2d 734 (8th Cir. 1986)); N. M. STAT. ANN. § 30-5-1 (1984) (parental consent, no bypass provisions); N.D. CENT. CODE § 14-02.1-03.1 (Supp. 1987) (parental consent and judicial bypass); 18 PA. CONS. STAT. ANN. § 3206 (Purdon 1983 & Supp. 1989) (parental consent and judicial bypass) (Planned Parenthood of Southwestern Pennsylvania v. Casey, 686 F.Supp. 1089 (Pa.D. 1988)) (preliminary injunction); R.I. GEN LAWS § 23-4.7-6 (1989) (parental consent and judicial bypass); S.C. CODE ANN § 44-41-30 (Law. Co-op. 1985) (minor who is unmarried and under 16 needs parental consent, no bypass provisions); S.D. CODIFIED LAWS ANN. § 34-23A-7 (1986) (parental consent, no judicial bypass provisions); TENN. CODE ANN. §§ 37-10-303, 37-10-304 (Supp. 1989) (parental consent and judicial bypass) (Planned Parenthood Assn. of Nashville v. McWherter, 716 F. Supp. 1064 (1989); WASH. REV. CODE ANN. § 9.02.070 (1988) (parental consent, no judicial bypass provisions) (unconstitutional in State v. Koome, 84 Wash.2d 901, 530 P.2d 260 (1975)).

64. Id.

65. Id., See also American Civil Liberties Union Reproductive Freedom Project, "Status of Parental Notification/Consent Legislation," January 1989.

66. 109 S.Ct. 3040 (1989).

67. The provisions of the Missouri statute include: (1) a preamble stating that "[t]he life of each human being begins at conception" and that "[u]nborn children have protectable interests in life, health, and well-being;" (2) a requirement that all abortions after the sixteenth week be performed only in hospitals; (3) a requirement that, prior to performing an abortion on a woman who is twenty or more weeks pregnant, a physician must determine whether the fetus is "viable" by performing "such medical examinations and tests as are necessary to make a finding of the gestational age, weight, and lung maturity of the unborn child;" (4) a prohibition on abortions at public facilities or performed by public employees; and (5) a prohibition on the use of public funds to counsel or encourage women to have abortions. MO. ANN.

STAT. §§ 188.025, .029, .205, .210, .215 (Vernon 1983 & Supp. 1989).

68. See note 101 infra for discussion.

69. ALA. CODE § 22-8-6 (1984) (minor may consent to legally authorized medical, health or mental health services to determine the presence of, or to treat pregnancy); ALASKA STAT. § 09.65.100(4) (1983) (minor may give consent for diagnosis, prevention or treatment of pregnancy); ARK. CODE ANN. § 20-9-602 (1987) (minor may consent to any surgical or medical treatment or procedures recommended by physician in connection with pregnancy or childbirth except interruption of pregnancy); CAL. CIV. CODE § 34.5 (West Supp. 1989) (minor may consent to hospital, medical, surgical care related to the prevention or treatment of pregnancy); DEL. CODE ANN. tit. 13, § 708 (1981) (minor may consent to any diagnostic, preventive, lawful therapeutic procedures, medical or surgical care and treatment, including X-rays for pregnancy treatment except abortion); FLA. STAT. § 743.065(1) (1987) (minor may consent to medical or surgical care or services relating to her pregnancy); GA. CODE ANN. § 31-9-2 (1985) (minor may consent to surgical or medical treatment or procedures not prohibited by law for pregnancy prevention thereof or childbirth); HAW. REV. STAT. §577A-2 (1988) (minor may consent to medical care and services by hospital, clinic or physician); KAN. STAT. ANN. § 38-123 (1986) (minor may consent to hospital, medical or surgical care related to pregnancy where no parent or guardian available); KY. REV. STAT. ANN. § 214.185 (Baldwin Supp. 1989) (minor may consent to diagnostic examination for pregnancy; physician may advise, prescribe for and treat minor regarding pregnancy without incurring liability solely for providing such services); LA. REV. STAT. ANN. § 40:1299.53 (West 1977) (minor may consent to surgical or medical treatment or procedures including autopsy in connection with pregnancy or childbirth); MD. HEALTH-GEN. CODE ANN. § 20-102 (1987) (minor may consent to treatment for or advice about pregnancy and health professionals shall not incur liability solely for providing such services); MICH. COMP. LAWS ANN. § 333.9132 (West Supp. 1989) (minor may consent to provision of prenatal and pregnancy related health care); MINN. STAT. § 144.343 (1988) (minor may consent to medical, mental and other health services to determine the presence of or to treat pregnancy and related conditions); MISS. CODE ANN. § 41-41-3(i) (Supp. 1988) (minor may consent to surgical or medical treatment or procedures not prohibited by law, in connection with pregnancy or childbirth); MO. REV. STAT. § 431.061 (1986) (minor may consent to any surgical, medical or other treatment not prohibited by law for pregnancy except abortion); MONT. CODE ANN. § 41-1-402 (1989) (minor may consent to medical or surgical care or services for the diagnosis, prevention and treatment of pregnancy); N.J. STAT. ANN. § 9:17A-1 (West 1976) (pregnant minor may consent to hospital, medical or surgical care and procedures related to her pregnancy or her child); N.M. STAT. ANN. § 24-1-13 (1986) (minor may consent to examination and diagnosis by licensed

physician for pregnancy); N.Y. PUB. HEALTH LAW § 2504(3) (McKinney 1985) (pregnant minor may consent to medical, dental, health and hospital services relating to prenatal care); N.C. GEN. STAT. § 90-21.5(a) (Supp. 1989) (minor may consent to medical health services for the prevention, diagnosis and treatment of pregnancy except abortion and sterilization); OKLA. STAT. tit. 63, § 2602(3) (1981) (minor may consent to services by health professionals for prevention, diagnosis and treatment of pregnancy. Health professional must also assume responsibility for counseling minor but shall incur no liability solely for providing services); PA. STAT. ANN. tit. 35, §10103 (Purdon 1977) (minor may consent to medical and health services to determine the presence of or to treat pregnancy); TENN. CODE ANN. § 63-6-223 (1986) (minor may receive examination, diagnosis and treatment for purpose of prenatal care without parental consent and health professional shall incur no liability solely for providing services); TEX. FAM. CODE ANN. § 35.03 (Vernon Supp. 1989) (minor may consent to hospital, medical or surgical treatment related to her pregnancy except abortion); UTAH CODE ANN. § 78-14-5(4) (1987) (any female regardless of age, may consent to any health care not prohibited by law in connection with pregnancy or childbirth); VA. CODE ANN. § 54.1-2969 (1988) (minor may consent to medical or health services required for birth control, pregnancy or family planning except sterilization).

70. DEL. CODE ANN. tit. 13, § 708 (1981) (minor must be twelve years old to consent).

71. ALA. CODE § 22-8-6 (1984) (minor may give effective consent to medical, health or mental health services to determine the presence of, or to treat venereal disease); ALASKA STAT. § 09.65.100(a)(4) (1983) (minor may consent to diagnosis and treatment of venereal disease); ARIZ. REV. STAT. ANN. § 44-132.01 (1987) (minor may consent to medical care related to the diagnosis or treatment of venereal disease); ARK. CODE ANN. § 20-16-508(a)(1) (1987) (minor may consent to medical or surgical care or services for venereal disease); COLO. REV. STAT. § 25-4-402(4) (1982) (minor may consent to diagnostic examination, prescription and treatment for venereal disease and health professionals relieved of liability for providing such services); CONN. GEN. STAT. § 19a-216 (1989) (minor may be examined and treated for venereal disease without parental consent); GA. CODE. ANN. § 31-17-7(a) (1985) (minor may consent to medical or surgical care or services for venereal disease); HAW. REV. STAT. § 577A-2 (1988) (minor may consent to medical care and services for venereal disease); ILL. REV. STAT. ch. 111, para. 4504 (1987) (minor may consent to diagnosis or treatment or counseling for venereal disease); IND. CODE § 16-8-5-1 (1982) (minor may consent to medical or hospital care or treatment for venereal disease); IOWA CODE § 140.9 (1989) (minor may consent to diagnosis or treatment for venereal disease); KAN. STAT. ANN. § 65-2892 (1985) (minor may consent to diagnostic examination and treatment for venereal

disease and health professional relieved of liability for providing such services); KY. REV. STAT. ANN. § 214.185 (Baldwin Supp. 1989) (minor may consent to diagnostic examination and treatment for venereal disease and health professionals relieved of liability for providing such services); LA. REV. STAT. ANN. § 40:1065.1(A) (West 1977) (minor may consent to medical or surgical care or services for venereal disease and health professional relieved of liability for providing such services); ME. REV. STAT. ANN. tit. 32, § 3292 (1988) (minor may receive medical care for treatment of venereal disease without parental consent); MD. HEALTH-GEN. CODE ANN. § 20-102(a), (c)(3) (1982) (minor may consent to treatment for or advice about venereal disease and health professional is relieved of liability for providing such services); MASS. GEN. L. ch. 111, § 117 (1988) (minors may receive a physical examination and treatment for venereal diseases and such treatment shall not be considered an assault or battery); MICH. COMP. LAWS ANN. § 333.5257 (1989) (minor may consent to medical or surgical care, treatment, or services for venereal disease); MINN. STAT. § 144.343(1) (1988) (minor may give effective consent for medical, mental and other health services to determine presence of or to treat venereal disease); MISS. CODE ANN. § 41-41-13 (1981) (minor may receive medical care for treatment of venereal disease without parental consent); MO. REV. STAT. § 431.061(4)(b) (1986) (minor may consent to surgical, medical, or other treatment or procedures for venereal disease); MONT. CODE. ANN. § 41-1-402(c) (1989) (minor may consent to medical or surgical care or services for prevention, diagnosis and treatment of venereal disease); NEV. REV. STAT. § 129.060 (1987) (minor may receive examination or treatment, or both, for venereal disease without parental consent); N.J. REV. STAT. ANN § 9:17A-4 (1989) (minor may consent to medical or surgical care or services for venereal disease); N.M. STAT. ANN. § 24-1-9 (1986) (minor may consent to examination and treatment for venereal disease); N.C. GEN. STAT. § 90-21.5(a) (1985 & Supp. 1989) (minor may consent to medical health services for the prevention, diagnosis and treatment of venereal disease); N.D. CENT. CODE § 14-10-17 (1981) (minor may consent to examination, care, or treatment for venereal disease); OHIO REV. CODE ANN. § 3709.241 (Anderson 1989) (minor may consent to diagnosis or treatment of venereal disease); OKLA. STAT. tit. 63, § 1-532.1 (1981) (minor may consent to examination and treatment for venereal disease); OR. REV. STAT. § 109.610 (1983) (minor may consent to hospital, medical or surgical care for diagnosis and treatment for venereal disease); PA. STAT. ANN. tit. 35, § 10103 (Purdon 1977) (minor may consent to medical and health services to determine presence of or to treat venereal disease); S.D. CODIFIED LAWS ANN. § 34-23-16 (1986) (minor may consent to diagnostic examination and treatment for venereal disease); VT. STAT. ANN. tit. 18, § 4226 (1982) (minor who is verified as having such disease may consent to medical treatment and hospitalization for venereal disease); VA. CODE ANN. § 54.1-2969(D)(1) (1988) (minor may consent to medical or health services needed to determine the presence of or to treat venereal disease); W. VA. CODE § 16-4-10 (1985) (minor may consent to examination, diagnosis, or treatment for venereal disease and health professional is relieved of liability for providing such services); WYO. STAT. § 35-4-131 (Supp. 1989) (minor may consent to examination and treatment for venereal disease and it shall not be considered an assault or battery).

72. CAL. CIV. CODE § 34.7 (West 1982) (minor may consent to hospital, medical and surgical care related to the diagnosis or treatment of sexually transmitted diseases); DEL. CODE ANN. tit. 16, § 710 (Supp. 1989) (minor may consent to examination and treatment for any sexually transmitted disease); FLA. STAT. ANN. § 384.30(1) (West 1989) (minors may receive an examination and treatment for sexually transmissible diseases without parental consent); NEB. REV. STAT. § 71-504 (Supp. 1988) (minor may consent to examination and treatment for sexually transmitted disease and health professional shall incur no liability for providing such services); N.H. REV. STAT. ANN. § 141-C:18(11) (Supp. 1988) (minor may receive medical diagnosis and treatment for a sexually transmitted disease without parental consent); N.Y. PUB. HEALTH LAW § 2305(2) (McKinney 1985) (minor may be diagnosed or treated for sexually transmissible disease without parental consent); R.I. GEN. LAWS § 23-11-11 (1989) (minor may consent to examination and treatment for sexually transmitted disease and it shall not constitute assault or battery); TENN. CODE ANN. § 68-10-104 (1987 & Supp. 1989) (minors may receive examination, diagnosis and treatment for sexually transmitted diseases without parental consent and health professional shall incur no liability for providing such services); TEX. FAM. CODE ANN. § 35.03(a)(3) (Vernon Supp. 1989) (minor may consent to the furnishing of hospital, medical, and surgical care for all sexually transmitted diseases and health professional shall incur no liability for providing services); UTAH CODE ANN. § 26-6-18 (1989) (minor may consent to medical care or services for sexually transmitted disease); WASH. REV. CODE § 70.24.110 (Supp. 1988) (minor may consent to hospital, medical and surgical care related to the diagnosis or treatment of a sexually transmitted disease); WIS. STAT. ANN. § 143.07(m) (West 1989) (minor may receive examination and treatment for sexually transmitted disease without parental consent and health professional shall incur no liability for providing such services).

73. ALA. CODE § 22-11A-19 (Supp. 1989) (minor may consent to medical care related to diagnosis or treatment of sexually transmitted disease); ALA. CODE § 22-8-6 (1984) (minor may consent to medical services related to diagnosis and treatment of venereal disease).

74. DEL. CODE ANN tit. 13, § 708(a) (1981) (minor may consent to diagnostic, preventative, lawful therapeutic procedures, medical or surgical care and treatment for contagious, infectious or communicable diseases); IDAHO CODE § 39-3801 (1985) (minor may consent to hospital medical, surgical care for infectious, contagious or communicable disease); TEX. FAM. CODE ANN. § 35.03

(Vernon Supp. 1989) (minor may consent to diagnosis and treatment of infectious, contagious or communicable disease legally required to be reported to public health authorities and health professional shall not incur liability for providing such services).

75. ALA. CODE § 22-8-6 (1984) (minor may consent to medical health or mental health services to determine presence of or to treat reportable disease); CAL. CIV. CODE § 34.7 (West 1982) (minor may consent to hospital, medical or surgical care related to diagnosis or treatment of infectious, contagious or communicable disease reportable to public health authorities); MONT. CODE ANN. § 41-1-402(c) (1989) (minor may consent to medical or surgical care or services for prevention, diagnosis and treatment of reportable communicable disease, including venereal disease); N.C. GEN. STAT. § 90-21.5 (Supp. 1989) (minor may consent to medical health services for prevention, diagnosis and treatment of venereal disease and other reportable diseases); OKLA. STAT. tit. 63, § 2602(A)(3) (1981) (minor may give consent for health services for prevention, diagnosis and treatment or reportable communicable disease and health professional shall not incur criminal liability for providing such services); PA. STAT. ANN. tit. 35, § 10103 (Purdon 1977) (minor may consent to medical and health services to determine presence of or to treat venereal disease and other reportable diseases); VA. CODE ANN. § 54.1-2969(D)(1) (1988) (minor may consent to medical or health services to determine the presence of or to treat venereal disease or any infectious or contagious disease required to be reported by public health authorities).

76. CAL. HEALTH & SAFETY CODE § 199.27 (West Supp. 1989) (minor under 12 deemed not competent to consent to HIV testing); COLO. REV. STAT. § 25-4-1405(6) (Supp. 1988) (minor may receive examination and treatment for HIV infection without parental consent); DEL. CODE ANN. tit. 16, § 1202(6)(f) (Supp. 1988) (minor 12 years of age and older may consent or refuse to consent to HIV testing); IOWA CODE § 141.22 (1989) (minor may consent to screening, services or treatment for AIDS); MICH. COMP. LAWS ANN. § 333.5127(i) (1989) (minor may consent to the provision of medical or surgical care, treatment or services for HIV subject to state regulations covering HIV testing); N.M. STAT. ANN. § 24-2B-3 (Supp. 1989) (minor may consent to HIV test); N.Y. PUB. HEALTH LAW §§ 2780 and 2781 (McKinney 1990) (individual, regardless of age, able to understand and appreciate the nature and consequences of proposed services and able to make informed decision may consent to HIV test); R.I. GEN. LAWS § 23-11-17 (1989) (person receiving treatment for sexually transmitted disease shall be offered HIV testing)..

77. ALA. CODE § 22-11A-19 (Supp. 1989); CAL. CIV. CODE § 34.7 (West 1982); CAL. HEALTH & SAFETY CODE § 199.27 (West Supp. 1989); DEL. CODE ANN. tit. 13, § 708 (1981); DEL. CODE ANN. tit. 16, § 1202 (Supp. 1988); ILL. REV. STAT. ch. 111, para. 4504 (1978); VT. STAT. ANN. tit. 18, § 4226 (1982).

78. IDAHO CODE § 39-3801 (1985); N.H. REV. STAT. ANN. § 141-C:18 (11) (Supp. 1988); N.D. CENT. CODE § 14-10-17 (1981); WASH. REV. CODE § 70.24.110 (Supp. 1988).

79. Alaska, Arkansas, District of Columbia, Oregon, Utah and Wyoming.

80. ALA. CODE § 22-8-6 (1984) (minor may consent to medical, health or mental health services to determine presence of, or to treat, drug dependency or alcohol toxicity); ARIZ. REV. STAT. ANN. § 36-2024(A) (Supp. 1988) (either a minor or a parent, legal guardian or other legal representative shall make an application for alcoholism evaluation and treatment); ARIZ. REV. STAT. ANN. § 44-133.01 (1987) (minor twelve years of age or older who is found upon diagnosis of a physician, to be under the influence of a dangerous drug or narcotic, which includes withdrawal symptoms, may be considered an emergency case and such minor is to be regarded as having consented to hospital or medical care needed for treatment. The consent of parent, parents, or legal guardian of such minor is not necessary to authorize hospital or medical care); CAL. CIV. CODE § 34.10 (West 1982) (minor may consent to medical care and counseling related to the diagnosis and treatment of a drug or alcohol related problem); COLO. REV. STAT. § 13-22-102 (1987) (minor may consent to examination, prescription, and treatment for drug treatment and health professionals shall incur no liability solely for providing services); COLO. REV. STAT. § 25-1-308(1) (1982) (alcoholic, including a minor, may apply for voluntary treatment directly to an approved treatment of facility); COLO. REV. STAT. § 25-1-309(1) (1982) (person intoxicated or incapacitated by alcohol, including a minor, may voluntarily admit herself to an approved facility for emergency treatment); CONN. GEN. STAT. § 19a-382 (1989) (minor may request treatment and rehabilitation for drug dependence); CONN. GEN. STAT. § 17-155t(a), (d) (1989) (alcoholic minor may apply for voluntary treatment directly to a public treatment facility. Request for withdrawal from an inpatient facility shall be made by a parent, legal guardian or by the minor if he was the original applicant); FLA. STAT. § 397.099 (1987) (minor may consent to rehabilitative or medical treatment for drug abuse or dependency); FLA. STAT. § 396.082 (1987) (minor may consent to treatment for alcoholism); GA. CODE ANN. § 37-7-8(b) (1982) (minor may consent to medical or surgical services for treatment of drug abuse); GA. CODE ANN. 37-8-31 (1982) (alcoholic minor may make application to a treatment program or facility for voluntary treatment of alcoholism--for discharge from inpatient facility, a written request shall be made by a parent, legal guardian, or by the minor if he was original applicant); HAW. REV. STAT. § 577-26(e) (1988) (minor may consent to counseling services for alcohol and drug abuse); IDAHO CODE § 37-3102 (1977) (minor may consent to treatment and rehabilitation for drug addiction or dependency); IDAHO CODE § 39-307 (1985) (minor may consent to voluntary treatment of alcoholism. If minor leaves treatment facility, request for discharge shall be made by

parent, guardian, or minor if he were the original applicant); ILL. REV. STAT. ch. 111, para. 4504 (1987) (minor who is an addict, an alcoholic or an intoxicated person may consent to medical care or counseling related to the diagnosis and treatment of such disease or drug use or alcohol consumption); IND. CODE § 16-13-6.1-23 (1982) (minor may receive treatment for alcoholism, alcohol abuse or drug abuse without parental consent); IOWA CODE §§ 125.2 and 125.33 (1989) (minor may consent to treatment or rehabilitation services for alcohol or drug/chemical dependency); KY. REV. STAT. ANN. §214.185 (Baldwin Supp. 1989) (minor may consent to diagnostic examination, prescription, advice and treatment for alcohol or other drug abuse or addiction and health professionals shall incur no liability solely for providing such services); ME. REV. STAT. ANN. tit. 32, § 3292 (1988) (minor may receive treatment for drug abuse or alcoholism without parental consent); MICH. COMP. LAWS ANN. §§ 333.6107(3), 333.6121 (West 1980) (minor may consent to care and treatment for alcohol or drug abuse); MINN. STAT. § 144.343(1) (1988) (minor may consent to medical, mental and other health services to determine the presence of or to treat conditions associated with alcohol and drug abuse); MISS. CODE ANN. § 41-41-14 (1981) (minor aged 15 may consent to treatment for mental or emotional problems resulting from alcohol or drugs); MO. REV. STAT. § 431.061(4)(c) (1986) (minor may consent to surgical or medical treatment for alcohol and drug abuse); MO. REV. STAT. § 631.105 (1986) (minor may consent to admission to alcohol/drug abuse facility); MONT. CODE ANN. § 41-1-402(c) (1989) (minor may consent to provision of medical or surgical care or services for drug and substance abuse, including alcohol); NEB. REV. STAT. § 71-5041 (1986) (minor may receive alcohol or drug abuse counseling or treatment providing minor understands the nature of the counseling or treatment and health professionals shall incur no liability solely for providing services); N.J. REV. STAT. ANN. § 9:17A-4 (West Supp. 1989) (a minor who is suffering from the use of drugs or is a drug dependent person may consent to treatment for drug use or drug abuse); N.J. STAT. ANN. § 26:2B-15 (West 1987) (person who is an alcoholic may voluntarily apply for treatment); N.C. GEN. STAT. § 90-21.5 (Supp. 1989) (minor may consent to medical health services for the prevention, diagnosis and treatment of abuse of controlled substances or alcohol); N.D. CENT. CODE § 14-10-17 (1971) (minor may consent to examination, care, or treatment for alcoholism or drug abuse); OHIO REV. CODE ANN. § 3719.012(A) (Anderson 1988) (minor may consent to treatment of drug-related conditions and health professional shall incur no liability solely for providing services); OKLA. STAT. tit. 63, § 2602(3) (West 1981) (minor may consent to services for prevention, diagnosis and treatment of drug and substance abuse or abusive use of alcohol); R.I. GEN. LAWS §40.1-4-9 (Supp. 1989) (minor may apply for voluntary treatment for alcoholism. A request for discharge from a treatment facility shall be made by a parent, guardian or the minor if he was the original applicant); R.I. GEN. LAWS § 14-5-4 (Supp. 1988) (minor may receive non-invasive, noncustodial treatment for substance abuse or chemical dependency when minor refuses permission to seek parental consent and professional determines such contact would not be helpful); S.C. CODE ANN. §§ 44-52-10, 44-52-20 (Law. Co-op. Supp. 1988) (application may be made for voluntary admission to a treatment facility by minor sixteen or older for treatment of chemical dependency on alcohol or other drugs); S.C. CODE ANN. § 44-52-40 (Law. Co-op. Supp. 1988) (if patient was admitted to treatment facility on his own application and the request for release is made by a parent, spouse or legal guardian, release may be conditional upon consent of patient); S.D. CODIFIED LAWS ANN. § 34-20A-50 (1986) (minor may make application to facility for treatment for alcohol or drug abuse); VA. CODE ANN. § 54.1-2969(D)(3) (1988) (minor may consent to medical or health services needed in case of outpatient care, treatment or rehabilitation for substance abuse as defined by 37.1-203 (alcohol and drugs)); VT. STAT. ANN. tit. 18, § 4226 (1982) (minor twelve or older who is found dependent on drugs or alcohol may consent to medical treatment and hospitalization and non-medical treatment for dependency upon regulated drugs or alcoholism); WASH. REV. CODE. § 69.54.060 (1987) (minor fourteen or older may consent to counseling, care, treatment or rehabilitation for drug or alcohol abuse); W.VA. CODE § 60A-5-504 (1989) (minor may receive examination, diagnosis, and treatment for any addiction to or dependency upon the use of a controlled substance without parental consent and health professionals shall incur no liability solely for providing services); W.VA. CODE § 60-6-23 (1989) (minor may receive examination, counseling, diagnosis and treatment for any addiction to or dependency upon the use of alcoholic liquor or non-intoxicating beer without parental consent and health professionals shall incur no liability solely for providing services); WIS. STAT. § 51.47 (1985-86) (minor twelve or older may consent to preventive, diagnostic, assessment, evaluation or treatment services for the abuse of alcohol or other drugs).

81. KAN. STAT. ANN. § 65-2892a (1985) (minor may consent to examination and treatment for drug abuse, misuse or addiction and health professional shall not incur liability solely for providing such services); LA. REV. STAT. ANN. §40:1096 (West 1977) (minor may consent to medical or surgical care or services for drug treatment); MASS. GEN. L. ch. 112, § 12E (1988) (minor twelve or older who is found to be drug dependent by two physicians may consent to hospital and medical care related to the diagnosis and treatment of drug dependency); NEV. REV. STAT. § 129.050 (1987) (minor may consent to hospital, medical, surgical or other care for the treatment of abuse of drugs and health professionals shall not incur liability solely for providing services); N.H. REV. STAT. ANN. § 318-B:12-a (1984) (minor twelve or older may consent to treatment for drug dependency); N.M. STAT. ANN. § 26-2-14 (1987) (minor may consent to drug abuse treatment); OR. REV. STAT. § 109.675(1) (1989) (minor fourteen and older may receive diagnosis and treatment for mental or emotional disorder or chemical dependency without parental consent); PA. STAT. ANN. tit. 71, § 1690.112 (Purdon Supp. 1989) (minor may consent to medical care or

counseling related to diagnosis or treatment for use of any controlled or harmful substance); TENN. CODE ANN. § 63-6-220 (1986) (minor may receive treatment for drug abuse by physician without parental consent); TEX. FAM. CODE ANN. § 35.03 (Vernon Supp. 1989) (minor may consent to hospital, medical, surgical, dental or counseling services for treatment of chemical addiction or dependency or condition directly related to chemical use).

82. DEL. CODE ANN. tit. 16, § 2210(b) (1983) (minor 12 or older may consent to treatment for alcoholism); N.Y. MENTAL HYG. LAW § 21.11 (McKinney 1988) (treatment for a minor's alcohol abuse or alcoholism may be provided without parental consent if physician believes their consent would have a detrimental effect on minor's treatment or if treatment is in best interest of minor and parents refuses to consent to such treatment).

83. ARIZ. REV. STAT. ANN. § 44-133.01 (1987) (minor must be twelve years of age or older to be regarded as having consented to drug abuse related health services); CAL. CIV. CODE § 34.10 (West 1982) (minor must be twelve years of age or older to consent to drug or alcohol abuse related health services); DEL. CODE ANN. tit. 16, §2210(b) (1983) (minor must be twelve years of age or older to consent to alcohol abuse related health services); IDAHO CODE § 37-3102 (1977) (minor must be sixteen years of age or older to consent to drug abuse related health services); ILL. REV. STAT. ch. 111, para. 4504 (1987) (minor must be twelve years of age or older to consent to drug or alcohol abuse related health services); MASS. GEN. L. ch. 112, § 12E (1988) (minor must be twelve years of age or older to consent to drug abuse related services); MISS. CODE ANN. § 41-41-14 (1981) (a minor must be fifteen years of age or older to consent to drug or alcohol abuse related health services); N.H. REV. STAT. ANN. § 318-B:12-a (1984) (minor must be twelve years of age to consent to drug abuse related health services); N.D. CENT. CODE § 14-10-17 (1971) (minor must be fourteen years of age or older to consent to drug or alcohol abuse related health services); OR. REV. STAT. ANN. § 109.675 (Supp. 1988) (minor must be fourteen years of age or older to receive treatment for chemical dependency without parental consent); S.C. CODE ANN. § 44-52-20 (Law. Co-op. Supp. 1988) (minor must be sixteen years or older to apply for admission to facility for treatment of drug or alcohol abuse); VT. STAT. ANN. tit 18, §4226 (1982) (minor must be twelve years of age or older to consent to drug or alcohol abuse related health services); WASH. REV. CODE § 69.54.060 (1987) (minor must be fourteen years of age or older to consent to drug or alcohol abuse related health services); WIS. STAT. § 51.47 (1985-86) (minor must be twelve years of age to receive drug or alcohol related services without parental consent).

84. Wadlington, W., "Minors and Health Care: The Age of Consent," Osgoode Hall L.Rev. 11:115-822, 1973.

85. ALASKA STAT. 47.30.545(D) (Supp. 1988) (community mental health center may treat minor under 18 who is at risk of removal from home for treatment of mental/emotional disturbances or exhibits behavior indicating risk of developing disturbance of a severe/persistent nature); COLO. REV. STAT. § 27-10-103 (Supp. 1988) (any person may make voluntary application for outpatient mental health services); FLA. STAT. § 394.56 (1987) (minor 12 and older may apply for outpatient services as long as a hearing held to verify voluntariness); GA. CODE ANN. § 37-3-20 (1982) (minor 12 and over may consent only to observation and diagnosis); ILL. REV. STAT. ch. 91 1/2 para. 3-501 (1987) (minor 14 or older may consent to counseling or psychotherapy on an outpatient basis; until parental consent is obtained, services are limited to five sessions of 45 minutes); KY. REV. STAT. ANN. § 214.185(2) (Baldwin Supp. 1989) (minor 16 or older may consent to outpatient mental health treatment); MD. HEALTH-GEN. CODE ANN. § 20-104 (1987) (minor 16 and older has the same capacity as adult to consent to consultation, diagnosis, and treatment of a mental or emotional disorder by a physician or clinic); MASS. GEN. L. ch. 123 § 10(b) (1988) (minor 16 or older may consent to outpatient treatment); MICH. COMP. LAWS ANN. § 330.1707 (West Supp. 1989) (minor 14 and older may consent to mental health services on an outpatient basis, excluding pregnancy, termination referral services and the use of chemotherapy. Services limited to 12 sessions or 4 months of services; after which services terminated or parents' consent must be obtained with consent of minor); MONT. CODE ANN. § 53-21-112 (1989) (a minor 16 and older may consent to receive "mental health services rendered by a facility that is not a state institution, or a person licensed to practice medicine or psychology"); N.H. REV. STAT. ANN. § 135-C:12 (Supp. 1989) ("Any person seeking services from the state mental health services system may apply to an approved community mental program or to a receiving facility. Application for a person under 18 years of age may be made by the person's parent or legal guardian"); N.M. STAT. ANN. § 43-1-17 (1984) (A minor may consent to "individual psychotherapy, group psychotherapy, guidance, counseling or other forms of verbal therapy which do not include aversive stimuli or substantial deprivations." Consent of minor or his parent without a court order for psychological surgery or convulsive therapy is invalid. A minor over 14 may consent to psychiatric medications and behavior modification programs involving aversive stimuli or substantial deprivations unless the parent objects.) N.Y. MENTAL HYG. LAW § 33.21 (McKinney 1988) (Outpatient mental health services with some exceptions may be provided to a minor seeking such services without parental consent if the mental health practitioner determines that services are being sought knowingly and voluntarily; the provision of services is indicated and necessary and requiring parental consent would have a detrimental impact on treatment or parent has refused to consent to treatment that is necessary and in the best interest of minor); N.C. GEN. STAT. § 90-21.5 (Supp. 1989) ("A minor may give effective consent to a physician for medical health services for the prevention, diagnosis

and treatment of emotional disturbance but services do not include commitment to hospital/institution."); OHIO REV. CODE ANN. § 5122.04 (Anderson 1989) ("Upon request of a minor 14 or order, a mental health professional may provide outpatient mental health services, excluding the use of medication, without the consent or knowledge of the minor's parent"); PA. STAT. ANN. tit. 50, § 7201 (Purdon Supp. 1989) ("Any person 14 years of age or older who believes he is in need of treatment and substantially understands the nature of voluntary treatment may submit himself to examination and treatment under this act, provided that the decision to do so is made voluntarily."); TENN. CODE ANN. § 33-6-102 (1984) (Minor aged 16 or over may apply to facility or professional for outpatient diagnosis, evaluation and treatment for mental illness); TEX. FAM. CODE ANN. § 35.03(g) (Vernon Supp. 1989) ("A minor may consent to counseling or counseling in conjunction with treatment by a physician, psychologist, counselor, or social worker licensed or certified by this state, within the scope of the professional's license, if the treatment is for sexual abuse, physical abuse, suicide prevention or chemical addiction, dependency or abuse. "A physician or psychologist, counselor, social worker . . . having reasonable grounds to believe that a child has been sexually or physically abused and/or is contemplating suicide and/or is involved in chemical addiction, dependency, or abuse may counsel the child without the consent or the child's parents"); VA. CODE ANN. § 54.1-2969 (D)(4) (1988) (Any minor shall be deemed an adult for the purposes of consenting to medical or health services needed in the case of outpatient care, treatment or rehabilitation for mental illnesses or emotional disturbance); WASH. REV. CODE § 71.34.030 (1987) (1) Any minor 13 years or older may request and receive outpatient treatment without consent of the minor's parent. Parental authorization is required for outpatient treatment of a minor under 13.

86. 442 U.S. 584 (1979).

87. ARIZ. REV. STAT. ANN. § 36-518 (Supp. 1989); CAL. WELF. & INST. CODE § 6000(b) (West 1984); COLO. REV. STAT. § 27-10-103 (Supp. 1988); CONN. GEN. STAT. § 17-205f (1989); GA. CODE ANN. § 37-3-20 (1982); HAW. REV. STAT. § 334-60.1 (1986); IDAHO CODE § 66-318 (1989); ILL. REV. STAT. ch. 91 1/2, para. 3-503 (1987); IND. CODE § 16-14-9.1-2 (Supp. 1987); IOWA CODE § 229.2 (1989); KY. REV. STAT. ANN. § 645.030 (Baldwin 1987); LA. REV. STAT. ANN. § 28:57 (West 1989); ME. REV. STAT. ANN. tit. 34-B, § 3831 (1988); MASS. GEN. L. ch. 123, § 10 (1988); MICH. COMP. LAWS ANN. § 330.1415 (West 1980); MINN. STAT. § 253B.04 (1988); MISS. CODE ANN. § 41-21-103 (Supp. 1989); MO. REV. STAT. § 632.110 (1986); NEV. REV. STAT. § 433A.140 (1987); N.H. REV. STAT. ANN. § 135-C:12 (Supp. 1988); N.Y. MENTAL HYG. LAW § 9.13 (McKinney 1988); N.D. CENT. CODE § 25-03.1-04 (1989); OHIO REV. CODE ANN. § 5122.02 (Anderson 1989); OR. REV. STAT. § 426.220 (1987); PA. STAT. ANN. tit. 50, § 7201 (Purdon Supp. 1989); S.C. CODE ANN. § 44-17-310 (Law. Co-op. 1984); S.D. CODIFIED LAWS ANN. § 27A-8-2 (1984); TEX.

REV. CIV. STAT. ANN. art. 5547-22(a) (Vernon Supp. 1990); UTAH CODE ANN. § 62A-12-228 (1989); WASH. REV. CODE § 71.34.030 (1987); WIS. STAT. § 51.13 (1985-86); WYO. STAT. § 25-10-106 (Supp. 1989).

88. See Weithorn, L.A., "Mental Hospitalization of Troublesome Youth: An Analysis of Skyrocketing Admission Rates," Stan. L. Rev. 40:773-838, 1988, which contends that the rising admission to psychiatric units of private hospitals are indicative of widespread misuse of commitment to control "troublesome" minors.

89. *Id*. at 782.

90. COLO. REV. STAT. § 27-10-103 (3.1) (Supp. 1988) (minor 15 years or older may make voluntary application); CONN. GEN. STAT. § 17-205(f) (1989) (minor 14 years or older may consent in writing to admission); FLA. STAT. § 394.465 (1987) (minor under 17 years may apply for inpatient admission and be admitted only after hearing to verify voluntariness); IDAHO CODE §§ 66-318, 66-320 (1989) (emancipated minor or minor 14 years and older may apply for admission); ILL. REV. STAT. ch. 91 1/2, para. 3-502 to 3-511 (1987) (minor 16 years or older may apply for admission); KAN. STAT. ANN. §§ 59-2905, 59-2907 (1987) (minor 14 years and older may make written application); KY. REV. STAT. ANN. § 645.030(3) (Baldwin 1987) (minor 16 years or older may apply and shall be informed of his rights); LA. REV. STAT. ANN. § 28:57 (West Supp. 1989) (minor 16 years or older may apply for admission); MD. HEALTH GEN. CODE ANN. § 20-104 (1987) (minor 16 years or older may consent to treatment by clinic); MASS. GEN. L. ANN. ch. 123 § 10 (1988) (minor 16 years or older may apply for admission); MINN. STAT. § 253B.04 (1988) (minor 16 years or older may request to be admitted for observation, evaluation, diagnosis, care and treatment without formal written application); MISS. CODE ANN. § 41-21-103 (Supp. 1988) (married persons or over 18 years or mentally ill minor 14 or older admitted in same manner as an adult involuntarily committed); MONT. CODE ANN. §§ 53-21-111, 53-21-112 (1989) (minor 16 years or older may consent to admission to mental health facility that is not a state institution); NEV. REV. STAT. § 433A.140 (1987) (any person may apply for admission); N.H. REV. STAT. ANN. § 135-C:12 (Supp. 1989) (any person may apply for admission); N.Y. MENTAL HYG. LAW § 9.13 (McKinney 1988) (minor 16 years or older who knowingly and voluntarily consented); N.C. GEN. STAT. § 90-21.5 (Supp. 1989) (minor may apply for admission in an emergency situation); PA. STAT. ANN. tit. 50, § 7201 (Purdon Supp. 1989) (minor 14 years or older who believes he is in need of treatment and substantially understands the nature of voluntary treatment may receive treatment); S.C. CODE ANN. § 44-17-310 (Law. Co-op. 1984) (minor 16 years or older may apply for admission); TENN. CODE ANN. § 33-6-101 (Supp. 1989) (minor 16 years or older may apply for admission. No persons less than 18 years may be admitted for more than 6 months in the period of year unless admissions committee approves); TEX. REV. CIV. STAT. ANN. art. 5547-22(b) (Vernon Supp. 1990) (minor 16 years or older may apply

for admission); UTAH CODE ANN. § 62A-12-228 (1989) (minor 16 years or older may apply for admission); VT. STAT. ANN. tit. 18, § 7503(a) (1987) (minor 14 or older may apply for admission); WASH. REV. CODE § 71.34.030 (1987) (minor 13 years or older with concurrence of professional in charge may admit himself); WIS. STAT. § 51.13 (1985-86) (minor 14 or older may be admitted with court approval if parent will not consent or cannot be found).

91. See supra n. 90.

92. DEL. CODE ANN., tit. 16 § 5123 (1983); HAW. REV. STAT. § 334-60.1 (1988) (consent of minor 15 or older and parent); KY. REV. STAT. ANN. § 645.030(2) (Baldwin 1987) (consent of minor 16 or older and one parent); MONT. CODE ANN. § 53-21-112 (1989) (minor who fails to join in consent of parents to admission treated as involuntary commitment); N.M. STAT. ANN. § 43-1-16 (1989); R.I. GEN. LAWS § 40.1-5-6 (1984); VT. STAT. ANN. tit. 18, § 7503(c) (1987); WASH. REV. CODE § 71.34.030(b) (1987); WIS.STAT. § 51.13 (1985-86).

93. National Conference of Commissioners on Uniform State Laws, Uniform Health-Care Information Act, Uniform Laws Annotated, Part I, 9:475-520 (St. Paul, Minn.: West Publishing Co., 1988).

94. Cleary, E.W., McCormick On Evidence 3rd ed. (St. Paul, Minn.: West Publishing Co., 1984).

95. See American Law Reports, "Doctors Disclosure of Confidential Information," A.L.R.4th 48:668-713 (Rochester, N.Y.: The Lawyer's Co-operative Publishing Co., 1986) at 673.

96. See the IJA-ABA standards, supra n. 3 at 56.

97. See, e.g., H.L. v. Matheson, 450 U.S. 398 (Burger, J.) (Powell, J. concurring); H.L. v. Matheson 420-25 (Stevens, J. concurring); Hofman, B.D., "The Squeal Rule: Statutory Resolution and Constitutional Implications -- Burdening the Minor's Right of Privacy," Duke L.J. 1984:1325-1357 1984 at 1348-51.

98. See, e.g., Boumil, M., "Dispensing Birth Control in Public Schools: Do Parents Have A Right To Know?" Seton Hall L.Rev. 18:356-377, 1988 at 374-76.

99. 450 U.S. 398 (1981).

100. 851 F.2d 1071 (8th Cir. reversed 109 S.Ct. 3040 (1989).

101. In Akron Center for Reproductive Health v. Slaby, 854 F.2d 852 (6th Cir. 1988), appeal filed sub nom. Ohio v. Akron Center for Reproductive Health, 109 S.Ct. 3239 (1989) (filed July 3, 1989), questions presented for review are:

> (1) Is judicial bypass procedure, which is component of parental consent statute regulating minor's right to abortion, constitutionally required component for parental notification statute? (2) Does Ohio parental notification statute, which contains judicial bypass procedure, provide constitutionally sufficient framework for ensuring due process rights of minor seeking abortion? (3) Can Ohio constitutionally require physician to provide notification to parent or other individual authorized to receive notice, of unemancipated, immature minor's intent to obtain abortion, and, if not, should physician notification requirement be severed to preserve integrity of statute and allow enforcement without offending provision?

In Hodgson v. Minnesota, 853 F.2d 1452 (8th Cir. 1988) (en banc), appeal filed (U.S. Feb. 3, 1989) (No. 88-1125), 110 S.Ct. 400 (1989) (filed July 3, 1989), the questions presented for review are:

> (1) Did Eighth Circuit err inholding constitutional requirement that both biological parents be notified prior to minor's abortion, regardless of whether they had ever married, or were separated or divorced, unless minor obtained order from state court? (2) Did Eighth Circuit err inholding that imposition of mandatory 48-hour waiting period, after constructive notification to both parents, was constitutional? (3) Did Eighth Circuit err in holding that Planned Parenthood v. Ashcroft, 462 U.S. 476 (1983), precludes invalidation of Minnesota parental notification/judicial bypass statute as unconstitutional in its entirety despite factual findings that after five years of operation it failed to promote any state interests, and, in fact, undermined family integrity,communication, and privacy interests for many minors? (4) Did Eighth Circuit err in holding that statute is consistent with Equal Protection Clause?

102. 1989 ARK. ACTS 270; GA. CODE ANN. § 15-11-112 (Supp. 1989) (notification and bypass)(preliminary injunction issued in Planned Parenthood Ass'n of Atlanta v. Harris, 691 F.Supp. 1419 (N.D. Ga. 1988) reh. denied, 108 S.Ct. 1064; IDAHO CODE §18-609(6) (1987) (notification); ILL. REV. STAT. ch. 38, para. 81-64(4) (1987) (notification and judicial bypass) (Zbaraz v. Hartigan, 584 F.Supp. 1452 (N.D. Ill. 1984), vacated in part and remanded 763 F.2d 1532 (7th Cir. 1985) aff'd by an equally divided Court. 484 U.S. 171 (per curiam), 98 L.Ed.2d 478, 108 S.Ct. 479 (Dec. 14, 1987) ("The 24 hour waiting period provision was severed from the rest of the statute and held unconstitutional by the Seventh Circuit as regards judicial bypass provision, the Seventh Circuit affirmed the district court's injunction pending promulgation of appellate rules by the State Supreme Court and remanded issue to district court for reconsideration when rules are promulgated. The U.S. Supreme Court affirmed the Seventh Circuit."); ME. REV. STAT. ANN. tit 22, § 1597

(1980) (notification) (enjoined in *Women's Community Health Center, Inc., v. Cohen*, 477 F. Supp. 542 (D.C. Me. 1979); MD. HEALTH-GEN. CODE ANN. § 20-103 (1982) (notification) (unconstitutional per 70 Op. Atty' Gen., No. 85-035, Dec. 31, 1985); MINN. STAT. §144.343 subd. 2-6 (1988) (notification and bypass) (constitutionality at issue in *Hodgson v. Minnesota*, 853 F.2d 1452 (8th Cir. 1988) (*en banc*), appeal filed (U.S. Feb. 3, 1989) (No. 88-1125); MONT. CODE ANN. § 50-20-107 (1989); NEV. REV. STAT. § 442.255 (1987) (notification) (preliminary injunction issued in *Glick v. McKay*, 616 F.Supp. 322 (D. Nev. 1985); OHIO REV. CODE ANN. § 2919.12 (Baldwin 1970) (notification and bypass) (constitutionality at issue in *Akron Center for Reproductive Health v. Slaby*, 854 F.2d 852 (6th Cir. 1988), *appeal filed sub nom. Ohio v. Akron Center for Reproductive Health,* 109 S.Ct. 3239 (1989) (filed July 3, 1989); UTAH CODE ANN. § 76-7-304 (1978) (notification); W.VA. CODE § 16-2F-3(a) (1989) (notification).

103. See Collins, C., "Abortion Focus Shifting to Teenagers," *The New York Times*, p. 1 (col. 3), Oct. 1, 1989; New York Times, "Kansas is Urged to Curb Abortion," *The New York Times*, p. 28 (col. 1), Nov. 9, 1989; New York Times, "Virginia Senators Stall Bill to Curb Abortion," *New York Times*, p. 47 (col. 5), Feb. 11, 1990.

104. HAW. REV. STAT. § 577A-2 (1988) (notification of parent at discretion of service provider after consulting with minor); KY. REV. STAT. ANN. §214.185(6) (Baldwin Supp. 1989) (notification of parents by physician if it would benefit the minor's health); MD. HEALTH-GEN. CODE ANN. § 20-102(c)(5), (e) (1987) (notification of parents at discretion of physician); N.C. GEN. STAT. §§ 90-21.5, 90-21.4(b) (Supp. 1989) (physician shall not notify parents without the permission of the minor unless essential to the minor's life or health). See also, UTAH CODE ANN. § 76-7-325 (Supp. 1989) (notification of parents if possible) (statutory provision held unconstitutional in *Planned Parenthood Ass'n v. Matheson*, 582 F. Supp. 1001 (D. Utah 1983).

105. In 1981 Congress amended the authorizing statute for the Title X Family Planning Program so as to provide that "[t]o the extent practical, entities which receive grants or contracts under this subsection shall encourage family participation in projects assisted under this section." 42 U.S.C. § 300(a) (1982). In 1983, pursuant to this amendment, the Secretary of Health and Human Services issued a regulation that provided that ten days after the prescription of contraceptive drugs or device for a minor, the minor's parent must be notified. 45 C.F.R. § 59.5(a)(12)(i)(A). In *New York v. Heckler*, 719 F.2d 1191 (2nd Cir. 1983), the Court of Appeals for the Second Circuit held that the 1981 Title X amendment did not authorize the regulation mandating parental notification. The Court found that Congress did not intend to require parental notification but merely to encourage parental involvement. In *Planned Parenthood Federation of America v. Heckler*, 712 F.2d 650 (D.C. Cir. 1983), the Court of Appeals for

the District of Columbia held that the regulation requiring parental notification was inconsistent with congressional intent with respect to Title X. See also Doe v. Pickett, 480 F.Supp. 1218, 1220-21 (S.D.W.Va. 1979) (State requirement of parental consent in family planning services under Title X constituted an additional eligibility requirement inconsistent with Title X goals.).

106. TENN. CODE ANN. § 63-6-223 (1986) (prenatal care without knowledge of minor's parent or guardian).

107. ALA. CODE § 22-8-6 (1984); ALASKA STAT. § 09.65.100(4) (1983); ARK. CODE ANN. § 20-9-602 (1987); CAL. CIV. CODE § 34.5 (West Supp. 1989); FLA. STAT. § 743.065(1) (1987); GA. CODE ANN. § 31-9-2(5) (1985); KAN. STAT. ANN. § 38-123 (1986); LA. REV. STAT. ANN. § 40:1299.53 (West 1977); MISS. CODE ANN. § 41-41-3 (Supp. 1988); N.M. STAT. ANN. § 24-1-13 (1986); N.Y. PUB. HEALTH LAW § 2504(3) (McKinney 1985); N.C. GEN. STAT. § 90-21.5(a) (Supp. 1988); PA. STAT. ANN. tit. 35, § 10103 (Purdon 1977); UTAH CODE ANN. § 78-14-5(4)(f) (1987); VA. CODE ANN. § 54.1-2969(D)(2) (eff. July 1, 1990).

108. CAL. CIV. CODE § 34.6 (West 1982) (Health professionals may, with or without the minor's consent disclose to the minor's parent or guardian information about the treatment given or needed if physician ahs reason to know the whereabouts of the parents or guardians); DEL. CODE ANN. tit. 13, § 708 (1981) (Physician may inform the minor's parents or guardian of the care needed or given if the physican deems in advisable under the circumstances, having primary regard for the interests of the minor); HAW. REV. STAT. § 577A-3 (1988) (Physician may inform the minor's parent or guardian regarding care needed or given after consulting with the minor); KY. REV. STAT. ANN. § 214.185 (Baldwin Supp. 1989) (Professional may notify minor's parent or guardian of treatment given or needed when it would benefit the minor's health); MD. HEALTH-GEN. CODE ANN. § 20-102 (1987) (Health professional is not required but may, even under minor's objection, inform the minor's parent or spouse of treatment given or needed except abortion); MICH. COMP. LAWS ANN. § 333.9132 (West Supp. 1989) (For medical reasons the physician may, but is not required to inform the minor's spouse, parent or guardian of the health care given or needed, even over the minor's express objection); MINN. STAT. § 144.346 (1988) (The professional may inform the minor's parent or guardian of treatment given or needed when failure to do so would jeopardize the minor's health); MO. REV. STAT. § 431.062 (1986) (Physician may inform the minor's parent or conservator of the care or treatment given or needed, with or without the minor's consent, if the physician has reason to know the whereabouts of the parent or conservator. However, if the minor is found not to be pregnant, no information may be disclosed); MONT. CODE ANN. § 41-1-403 (1989) (Health professional may but is not obligated to inform minor's spouse, parent or guardian of treatment given or

needed when: severe complications are present or anticipated; major surgery or prolonged hospitalization is necessary; failure to inform would jeopardize the safety and health of the minor, his siblings, or the public; informing would benefit the minor's physical and mental health and family harmony; or the hospital requires a third party commitment to pay for services. However, no notification is allowed when a minor is found not to be pregnant, not afflicted with venereal disease or not suffering from drug or alcohol abuse.); N.J. STAT. ANN. § 9:17A-5 (West 1986) (Physician is not required but may inform the minor's spouse parent or guardian of treatment needed or given, even over the minor's express objection); OKLA. STAT. tit. 63, § 2602 (1981) (Notification of the minor's spouse, parent or guardian is within the discretion of the health professional. Disclosure to any health professional, school, law enforcement agency or official, court authority, government agency or official employer requires the minor's consent unless necessary for the health of the minor and public); TEX. FAM. CODE § 35.03 (Vernon Supp. 1989) (Physician may inform the minor's parent or guardian of treatment needed or given with or without the minor's consent).

109. CONN. GEN. STAT. § 19a-216 (1989) (examination and treatment of minor is confidential and shall not be divulged, including the sending of a bill for the services to any person other than the minor, except for purposes of reports. If, however, minor is twelve or under, a report must be made to children and youth services); FLA. STAT. § 384.30(2) (1989) (treatment of minor is confidential and shall not be divulged in any direct or indirect manner, such as sending a bill for services rendered to a parent or guardian, except as required by reporting law, etc.); NEB. REV. STAT. § 71-504 (Supp. 1988) (treatment of minor may be without notification of parents or guardian); N.H. REV. STAT. ANN. § 141-C:18 (Supp. 1988) (treatment of minor without knowledge of parent or guardian); N.Y. PUB. HEALTH LAW § 2305(2) (McKinney 1985) (treatment of minor without knowledge of parents or guardian); S.D. CODIFIED LAWS ANN. § 34-23-17 (1986) (treatment by county or state health department without notification to the minor's parents); TENN. CODE ANN. § 68-10-104 (1987 & Supp. 1989) (treatment of mionr without knowledge of parent or guardian); W.VA. CODE § 16-4-10 (1985) (treatment of minor without the knowledge of the minor's parent or guardian).

110. ALA. CODE § 22-11A-19 (Supp. 1989) (health professional is not required, but may inform the minor's parent or guardian of treatment given or needed); ARK. CODE ANN. § 20-16-508(b) (1987) (physician is not required, but may inform spouse, parent or guardian of any treatment given or needed, even over the express objection of the minor); DEL. CODE ANN. tit. 13, § 708(c) (1981) (physician may inform the minor's parent or guardian of any treatment needed or given if he deems is advisable, having primary regard for the interest of the minor); COLO. REV. STAT. § 25-4-402(4) (1982) (physician may treat minor without notification to

parent or guardian); GA. CODE ANN. § 31-17-7(b) (1985) (health professional is not required, but may inform the minor's spouse, parent or guardian of treatment given or needed, even over the minor's express objection); HAW. REV. STAT. § 577A-3 (1988) (health professionals may inform the minor's spouse, parent or guardian of medical care or services provided to the minors after consulting with the minor. If the minor is not afflicted with venereal disease, information may be disclosed at the discretion of the physician after consulting with the minor); ILL. REV. STAT. ch. 111, para. 4504, 4505 (1987) (professional may, but is not required to, inform minor's parents or guardian of treatment given or needed); KAN. STAT. ANN. § 65-2892 (1985) (physician may, but is not required to, inform the minor's spouse, parent or guardian, or fiance of treatment given or needed without the minor's consent); KY. REV. STAT. ANN. § 214.185(5) (Baldwin Supp. 1989) (professional may inform minor's parent or guardian of treatment needed or given if he believes it would benefit the minor's health); LA. REV. STAT. ANN. § 40:1065.1(c) (West 1977) (professional may, but is not required to, inform minor's spouse, parent or guardian of treatment needed or given even over the express objection of the minor); ME. REV. STAT. ANN. tit. 32, § 3291 (1988) (professional is not prohibited from informing minor's parent or guardian); MD. HEALTH-GEN. CODE ANN. § 20-102(e) (1987) Professional may but is not required to, inform minor's parent or guardian of treatment needed or given even over the express objection of the minor); MICH. COMP. LAWS § 333.5257(2) (1979) (for medical reasons a health professional may, but is not required to, inform minor's spouse, parent or guardian of treatment given or needed, notwithstanding the minor's express objection); MINN. STAT. § 144.346 (1988) (professional may inform minor's parent or guardian of treatment given or needed when failure to do so would jeopardize the minor's health); MO. REV. STAT. § 431.062(3) (1986) (physician may inform the parent or guardian of treatment given or needed, without the minor's consent, if the physician has reason to know their whereabouts, but if minor is not afflicted with disease, no disclosure may be made); MONT. CODE ANN. § 41-1-403 (1989) (health professional may but is not obligated to inform minor's spouse, parent or guardian of treatment given or needed when: severe complications are present or anticipated; major surgery or prolonged hospitalization is necessary; failure to inform would jeopardize the safety and health of the minor, his siblings, or the public; informing would benefit the minor's physical and mental health and family harmony; or the hospital requires a third party commitment to pay for services, but no notification is allowed when a minor is found not to afflicted with venereal disease.); TEX. FAM. CODE ANN. § 35.03 (Vernon Supp. 1989) (physician may inform the minor's parents or guardian of the treatment given or needed, with or without the minor's consent).

111. ALA. CODE § 22-8-6 (1984); ALASKA STAT. § 09.65.100(a)(4) (1983); CAL. CIV. CODE § 34.7 (West 1982); IDAHO CODE § 39-3801 (1985).IND. CODE § 16-8-5-1 (1982); IOWA CODE § 140.9 (1989); MASS.

GEN. L. ch. 111, § 117 (1988); MISS. CODE ANN. § 41-41-13 (1981); NEV. REV. STAT. § 129.060 (1987); N.J. REV. STAT. ANN. § 9:17A-4 (1989); N.M. STAT. ANN. § 24-1-9 (1986); N.C. GEN. STAT. § 90-21.5(a) (1985 & Supp. 1989); OHIO REV. CODE ANN. § 3709.241 (Anderson 1989); OKLA. STAT. tit. 63, § 1-532.1 (1981); PA. STAT. ANN. tit. 35, § 10103 (Purdon 1977); R.I. GEN. LAWS § 23-11-11 (1989); S.D. CODIFIED LAWS ANN. § 34-23-16 (1986); UTAH CODE ANN. § 26-6-18 (1988); VA. CODE ANN. § 54.1-2969 (1988); WASH. REV. CODE § 70.24.110 (Supp. 1988); WIS. STAT. § 143.07(m) (1989);WYO. STAT. § 35-4-131 (Supp. 1989).

112. VT. STAT. ANN. tit. 18, § 4226 (1982) (parent shall be notified if the condition of the minor requires immediate hospitalization).

113. COLO. REV. STAT. § 25-4-1405(6) (Supp. 1988) (examination and treatment of minor is absolutely confidential and shall not be divulged to any person other than the minor except for purposes of required reports, but the minor is less than sixteen or not emancipated, the physician may inform the minor's parent; DEL. CODE ANN. tit. 16, § 1203 (Supp. 1988) (Disclosure may be made of HIV test to patient's legal guardian); MICH. COMP. LAWS § 333.5127(2) (1989) (for medical reasons, the physician may, but is not obligated to, inform minor's spouse or parent of treatment needed or given, even over the minor's express objection).

114. CAL. HEALTH & SAFETY CODE § 199.27 (West Supp. 1990).

115. IOWA CODE § 141.22 (1989) (minor shall be informed that there is no disclosure except when HIV test is positive, in which case the parent or guardian is to be informed. Testing facilities shall have a program to assist minors and legal guardians with the notification process which emphasizes the need for family support and assists in making available the resources to accomplish that goal with testing facilities precluded by federal regulation or statute from disclosure with being exempt from notification requirement, but not from assistance program requirement).

116. COLO. REV. STAT. § 13-22-102 (1987) (treatment of minor for addiction to drugs without notification of parents or guardian); CONN. GEN. STAT. § 19a-382 (West 1987) (information about minor's drug treatment shall not be reported or disclosed to minor's parent or guardian without minor's consent); IDAHO CODE § 37-3102 (1977) (if a minor is sixteen or older, no disclosure may be made to minor's parent or guardian concerning drug abuse treatment without the minor's consent, but minor shall be counseled as to the benefits involving parents or guardian in treatment or rehabilitation); IOWA CODE § 125.33 (1989) (information about minor's treatment for drug or alcohol abuse should not be reported or disclosed to minor's parent or guardian without the minor's consent); N.J. STAT. ANN. § 9:17A-4 (West Supp. 1989) (treatment for drug abuse is confidential information between physician and

minor, and neither the minor nor physician shall be required to report such treatment when it is the result of voluntary consent); N.C. GEN. STAT. § 90-21.4(b) (Supp. 1989) (physician shall not notify parent or guardian without minor's permission unless notification is essential to life or health of minor. If the parent contacts physician concerning treatment, he may give information); W.VA. CODE § 60-6-23(e) (1989) (treatment of a minor for alcoholism without knowledge of minor's parent or guardian); W.VA. CODE § 60A-5-504 (1989) (treatment of minor for drug abuse without parental knowledge).

117. GA. CODE ANN. § 37-7-8(c) (1982) (physician may, but is not required to, inform the minor's parent or guardian of the treatment needed or given, even over express objection of minor); ILL. REV. STAT. ch. 111, para 4505 (1987) (professional treating minor for drug use may, but is not required to, inform the minor's parent or guardian of treatment given or received and professional shall, upon the minor's consent, make reasonable efforts to involve the minor's family in treatment unless it would be detrimental to the minor); IND. CODE § 16-13-6.1-23 (1982) (minor may receive treatment for drug or alcohol abuse without parental notification, but disclosure is discretionary with department or facility); KY. REV. STAT. ANN. § 214.185(7) (Baldwin Supp. 1989) (the professional may inform the minor's parent or legal guardian of treatment given or needed if in physician's judgment it would benefit the minor's health); LA. REV. STAT. ANN. § 40:1096(c) (West 1977) (professional may, but is not required to, inform parent or guardian of treatment needed or given even over the express objection of the minor); ME. REV. STAT. ANN. tit. 32, § 3292 (1988) (professional treating minor for abuse of drugs or alcohol is not required but may inform the minor's parent or guardian of treatment); MICH. COMP. LAWS § 333.6121 (1980) (for medical reasons the health professional may, but is not required to, inform the minor's spouse, parent or guardian of treatment given or needed, even over minor's express objection); MINN. STAT. § 144.346 (1988) (professional may inform the minor's parent or guardian of treatment given or needed when failure to do so would jeopardize the minor's health); MISS. CODE ANN. § 41-41-14 (1981) (professional may, but is not required to, inform the minor's spouse, parent or guardian, even over the minor's express objection); MO. REV. STAT. § 431.062 (1986) (physician may, with or without the minor's consent, inform the minor's parent or guardian of care given or needed except when minor is found not to be pregnant or not afflicted with a venereal disease, or not suffering from drug or alcohol abuse); MONT. CODE ANN. § 41-1-403 (1989) (health professional may, but is not obligated to, inform minor's spouse, parent or guardian of treatment given or needed when: severe complications are present or anticipated; major surgery or prolonged hospitalization is necessary; failure to inform would jeopardize the safety and health of the minor, his siblings, or the public; informing would benefit the minor's physical and mental health and family harmony; or the hospital

requires a third party commitment to pay for services; but but no notification is allowed when a minor is found not to be suffering from drug or alcohol abuse.); OKLA. STAT. tit. 63, § 2602 (1981) (notification of the minor's spouse, parent or guardian is within the discretion of the health professional and disclosure to any health professional, school, law enforcement agency or official, court authority, government agency or official employer requires the minor's consent unless necessary for the health of the minor and public); PA. STAT. ANN. tit. 71, § 1690.112 (Purdon Supp. 1989) (physician may use his own discretion in determining whether to notify minor's parents of drug abuse treatment); TEX. FAM. CODE ANN. § 63-6-220(b) (Vernon 1986) (physician may use his own discretion in determining whether to notify minor's parents of drug abuse treatment); TEX. FAM. CODE ANN. § 35.03 (Vernon Supp. 1989) (physician may inform the minor's parent or guardian of treatment needed or given with or without the minor's consent).

118. ALA. CODE § 22-8-6 (1984) (drug and alcohol); ARIZ. REV. STAT. ANN. § 36-2024 (Supp. 1989) (alcohol treatment); ARIZ. REV. STAT. § 44-133.01 (1987) (drug treatment); COLO. REV. STAT. § 25-1-308(1) (1982) (alcoholism); DEL. CODE ANN. tit. 16 § 2210(b) (1983) (alcoholism); FLA. STAT. § 397.099 (1987) (drug treatment); GA. CODE ANN. § 37-8-31 (1982) (alcoholism); IDAHO CODE § 39-307 (1985) (alcoholism); KAN. STAT. ANN. § 65-2892a (1985) (drug abuse); MASS. GEN. L. ch. 112, § 12E (1988) (drug abuse); N.H. REV. STAT. § 318-B:12-a (1984) (drug treatment); N.D. CENT. CODE § 14-10-17 (1971) (drug or alcohol abuse); R.I. GEN. LAWS § 40.1-4-9 (Supp. 1989) (alcoholism); S.C. CODE ANN. § 44-52-20 (Law. Co-op. Supp. 1988) (alcohol or drug abuse); S.D. CODIFIED LAWS ANN. § 34-20A-50 (1986) (alcohol or drug abuse); VA. CODE ANN. § 54.1-2969 (Supp. 1989) (effective July 1, 1990) (drug and alcohol abuse); WASH. REV. CODE § 69-54-060 (1987) (drug or alcohol abuse).

119. CAL. CIV. CODE § 34.10 (West 1982) (health professional shall state in minor's treatment record whether and when he attempted to contact the minor's parents or guardian, whether such attempts to contact were successful; or the reasons why it would not be appropriate to contact the parents or guardian); HAW. REV. STAT. § 577-26(f) (1988) (while providing counseling services to minor for alcohol or drug abuse, counselor shall attempt to "open the lines of communication" between the minor and spouse, parent or guardian, provided such action is deemed beneficial in achieving the desired objectives); NEB. REV. STAT. § 71-5041 (1986) (professional providing alcohol or drug abouse counseling or treatment to a minor shall attempt to involve minor's family); R.I. GEN. LAWS § 14-5-4 (Supp. 1989) (during course of treatment for substance abuse, professional shall make attempts to obtain permission from minor to secure parental consent and involvement in treatment).

120. COLO. REV. STAT. § 25-1-309(5) (1989) (if an intoxicated minor is admitted to a treatment facility, his family shall be notified as promptly as possible); ILL. REV. STAT. ch. 111, para. 4504 (1987) (when a minor twelve and older is being treated for alcohol use, professional shall notify the minor's parent or guardian after the second treatment unless professional believes that notification would jeopardize the course of the minor's treatment. In no case shall a period of three months elapse without the minor's parent or guardian being notified of treatment.); NEV. REV. STAT. § 129.050(3) (1987) (physician who treats minor shall make every reasonable effort to inform parents or guardian within a reasonable time after treatment); N.J. STAT. ANN. § 26:2B-15 (West 1987) (when an alcoholic or intoxicated minor is admitted to a facility, the minor's family or guardian shall be notified); N.Y. MENTAL HYG. LAW § 21.11 (McKinney 1988) (professional shall attempt to involve minor's parents or guardian in alcoholism treatment, but if professional judges that this involvement would have a detrimental effect on the course of treatment, or minor's parent refuses consent, and physician believes treatment necessary for minor's best interest, treatment may be provided without parental involvement); VT. STAT. ANN. tit. 18, § 4226 (1982) (parents shall be notified if the condition of the minor requires immediate hospitalization as a result of drug usage of alcoholism); WIS. STAT. § 51.47 (1985-86) (drug or alcohol abuse evaluation or treatment for minor without parental notification but notification them of services rendered as soon as practicable).

121. 42 C.F.R., Part 2 § 2.14 (1987).

122. Confidentiality of Alcohol and Drug Abuse Patient Records: Final Rule, 52 Fed.Reg. 21798-99 (1987).

123. ALASKA STAT. § 47.30.545 (Supp. 1989); COLO. REV. STAT. § 27-10-103(1) (Supp. 1988); FLA. STAT. § 394.56 (1987); GA. CODE ANN. § 37-3-20 (1982); MASS. GEN. L. ch. 123, § 10(b) (1988); MONT. CODE ANN. § 53-21-112 (1989); N.H. REV. STAT. ANN. § 135-C:12 (Supp. 1989); N.M. STAT. ANN. § 43-1-17(A) (1989); PA. STAT. ANN. tit. 50, § 7201 (Purdon Supp. 1989); TENN. CODE ANN. § 33-6-102 (1984); VA. CODE ANN. § 54.1-2969(D)(4) (1988); WASH. REV. CODE § 71.34.030(1) (1987).

124. MICH. COMP. LAWS ANN. § 330.1707(c) (West Supp. 1989) (minor's parent shall not be informed of outpatient services without the consent of the minor unless the mental health professional determines there is a compelling need for disclosure based on a substantial probability of harm to the minor or to other persons, and the minor is informed of disclosure); N.C. GEN. STAT. § 90-21.4(b) (Supp. 1989) (physician shall not notify parent or guardian without the permission of the minor unless notification is essential to the life or health of the minor, but if parent contacts physician concerning treatment, physician may give

information); N.Y. MENTAL HYG. LAW § 33.21 (McKinney 1988) (outpatient treatment of minor without parental or guardian involvement is permissible when professional determines that minor knowingly and voluntarily seeks services, services are indicated and necessary, and parental involvement would have a detrimental effect on treatment or if parents refuse to consent and physician determines such treatment is necessary and in the minor's best interest. Documentation of preceding requirements is necessary); OHIO REV. CODE ANN. § 5122.04(A) (Anderson 1989) (minor's parent shall not be informed of mental health services provided without minor's consent unless professional determines there is a compelling need for disclosure based on a substantial probability of harm to the minor or others, and the minor is notified of disclosure).

125. ILL. REV. STAT. ch. 91 1/2, para. 3-501 (1987) (minor's parent or guardian shall not be informed of counseling or psychotherapy without minor's consent unless the facility director believes it is necessary, in which case the minor shall be so informed); KY. REV. STAT. ANN. § 214.185(6) (Baldwin Supp. 1989); MD. HEALTH-GEN. CODE ANN. § 20-104(b) (1987) (physician may but is not required to disclose to minor's spouse, parent or guardian information about treatment provided or needed, even over express objection of minor); TEX. FAM. CODE ANN. § 35.03(g)(2) (Vernon Supp. 1989) (professional may, with or without minor's consent, advise minor's parent or guardian of treatment given or needed).

126. CAL. CIV. CODE § 25.9 (West 1982) (mental health treatment or counseling shall involve minor's parent unless professional deems involvement inappropriate, and a record shall cbe made of notification attempts or reasons for inappropriateness of attempts.)

127. FLA. STAT. § 394.465(2) (1987); LA. REV. STAT. ANN. § 28:57 (West Supp. 1989); MASS. GEN. L. ch. 123 § 10 (1988); MINN. STAT. § 253B.04 (1988); MISS. CODE ANN. § 41-21-103 (Supp. 1988); MONT. CODE ANN. § 53-21-112 (1989); NEV. REV. STAT. § 433A.140 (1987); N.H. REV. STAT. ANN. § 135-C:12 (Supp. 1989); N.Y. MENTAL HYG. LAW § 9.13 (McKinney 1988); PA. STAT. ANN. tit. 50, § 7201 (Purdon Supp. 1989); S.C. CODE ANN. § 44-17-310 (Law. Co-op. 1984); TENN. CODE ANN. § 33-6-101 (Supp. 1989); TEX. REV. CIV. STAT. ANN. art. 5547-22(b) (Vernon Supp. 1990); UTAH CODE ANN. § 62A-c12-228 (1989).

128. MD. HEALTH-GEN. CODE ANN. § 20-104 (1987) (professional may, but need not inform the minor's spouse, parent or guardian of treatment needed or given, even over minor's express objection).

129. COLO. REV. STAT. § 27-10-103(3.1) (Supp. 1988) (when minor applies for voluntary admission an independent investigation into the minor's background, using all available sources, including but not limited to, the parents or guardian is conducted); CONN. GEN.

STAT. § 17-205f (1987) (parents of minor fourteen or older are to be notified of hospitalization within five days of admission); IDAHO CODE § 66-318 (1989) (director of facility will notify parents of minor's admission); ILL. REV. STAT. ch. 91 1/2, para. 3-502 (1983) (parent shall be immediately informed of minor's voluntary admission); KAN. STAT. ANN. § 59-2905 (1983) (minor's parent or guardian shall be notified promptly of minor's voluntary admission); KY. REV. STAT. ANN. § 645.220 (Baldwin Supp. 1989) (notice of minor's admission shall be given to parent within twenty-four hours of admission); WASH. REV. CODE § 71.34.030(2)(c) (1987) (notice of minor's admission shall be in the form most likely to reach minor's parents within twenty-four hours of voluntary admission); WIS. STAT. § 51.13 (1985-86) (when minor petitions court for admission hearing because parents refuse consent or cannot be found, a copy of the petition and a notice of hearing shall be served upon parent or guardian).

130. See supra notes 123-129.

131. FLA. STAT. § 743.064(3) (1987) (notification as soon as possible after emergency medical care is administered and hospital records shall reflect the reason such consent was not initially obtained.); KY. REV. STAT. ANN. § 214.185(6) (Baldwin Supp. 1989) (professional may inform the minor's parent or guardian of any treatment needed or given when he judges it would benefit the minor's health); MD. HEALTH-GEN. CODE ANN. § 20-102(e) (1982) (physician is not required, but may, without minor's consent, inform the minor's parent or guardian concerning treatment needed or given, except abortion.); MASS. GEN. L. ch. 112, § 12F (1988) (no notification unless physician believes minor's condition such that his life or limb is endangered, in which case physician shall notify minor's parents and inform the minor of the notification); MINN. STAT. § 144.344 (1988) (professional may inform the minor's parent or guardian of treatment given or needed when failure to do so would jeopardize the minor's health); MONT. CODE § 41-1-403 (1989) (health professional may but is not obligated to inform minor's spouse, parent or guardian of treatment given or needed when: severe complications are present or anticipated; major surgery or prolonged hospitalization is necessary; failure to inform would jeopardize the safety and health of the minor, his siblings, or the public; informing would benefit the minor's physical and mental health and family harmony; or the hospital requires a third party commitment to pay for services.); NEV. REV. STAT. § 129.030(3) (1987) (health professional shall attempt to gain minor's consent to communicate with minor's parent or legal guardian, and shall note such attempts, but if such efforts would jeopardize treatment necessary for minor's life or necessary to avoid a serious and immediate threat to the minor's health, the professional may omit such efforts and make note of the reasons); OKLA. STAT. tit. 63, § 2602(B) (1981) (professional shall be required to make a reasonable attempt to inform the minor's spouse, parent or guardian of emergency treatment.); TENN. CODE ANN. § 63-

6-222(b) (1986) (treatment shall be commenced only after a reasonable effort is made to notify minor's parents or guardian); VA. CODE ANN. § 54.1-2969(G) (1988) (reasonable efforts must be made to notify the minor's parents as soon as practicable).

132. ALA. CODE § 22-8-3 (1984); ARIZ. REV. STAT. ANN. § 36-2271(c) (1986); ARK. CODE ANN. § 20-9-603(1) (1987); DEL. CODE ANN. tit 13, § 707(a)(5) (1981); GA. CODE ANN. §§ 31-9-2, 31-9-3 (1985); ILL. REV. STAT. ch. 111, para. 4503 (1987); IOWA CODE § 147A.10 (1989); KAN. STAT. ANN. § 65-2891 (Supp. 1987); LA. REV. STAT. ANN. § 40:1299.54 (West Supp. 1989); MO. REV. STAT. § 537.037 (1986); NEB. REV. STAT. § 7105512 (1986); N.M. STAT. § 24-10-2 (1986); N.Y. PUB. HEALTH LAW § 2504 (McKinney 1985); N.D. CENT. CODE § 14-10-17.1 (1981); PA. STAT. ANN. tit. 35, § 10104 (Purdon 1977); R.I. GEN. LAWS. § 23-4.6-1 (1989); S.C. CODE ANN. § 20-7-290 (Law. Co-op. 1984); S.D. CODIFIED LAWS ANN. § 20-9-4.2 (1987): WYO. STAT. ANN. § 14.1-101 (1986 & Supp. 1989).

133. ARIZ. REV. STAT. ANN. § 44-132 (1987); ARK. CODE ANN. § 20-9-602 (1987); IND. CODE § 16-8-12-2 (1988); MISS. CODE ANN. § 41-41-3(g) (Supp. 1988); MONT. CODE § 41-3-408 (1989); N.M. STAT. ANN. § 24-10-1 (1986); N.C. GEN. STAT. § 90-21.5(b) (1985); WYO. STAT. § 14-1-101 (1986 & Supp. 1989).

134. CAL. CIV. CODE § 63 (West 1982) (emancipated minor may consent to medical, dental or psychiatric care without parental knowledge); CONN. GEN. STAT. § 46b-150d (1987) (emancipated minor may consent to medical, dental or psychiatric care without parental knowledge); KY. REV. STAT. ANN. § 214.185(6) (Baldwin Supp. 1989) (professional may inform the minor's parent or legal guardian of treatment given or needed if in physician's judgment it would benefit the minor's health.); MONT. CODE § 41-1-403 (1989) (health professional may but is not obligated to inform minor's spouse, parent or guardian of treatment given or needed when: severe complications are present or anticipated; major surgery or prolonged hospitalization is necessary; failure to inform would jeopardize the safety and health of the minor, his siblings, or the public; informing would benefit the minor's physical and mental health and family harmony; or the hospital requires a third party commitment to pay for services); NEV. REV. STAT. § 129.130(d) (1989) (emancipated minor may consent to medical, dental or psychiatric care without parental knowledge); N.M. STAT. ANN. § 28-6-6 (1987) (emancipated minor may consent to medical, dental or psychiatric care without parental knowledge); OKLA. STAT. tit. 63, § 2602 (1981) (notification of the minor's spouse or parent is within the discretion of the health professional, except in life threatening emergencies, but disclosure to any health professional, school, law enforcement agency or official, court authority, government agency or official employer requires the minor's consent unless necessary for the health of the minor and public); VA. CODE ANN. § 16.1-334 (1988) (emancipated minor may consent to medical, dental, or psychiatric care without parental knowledge).

135. ALA. CODE § 22-8-4 (1984) (no notification provision); ARIZ. REV. STAT. ANN. § 44-132 (1987) (no notification provision); ARK. CODE ANN. § 20-9-602(3) (1987) (no notification provision); CAL. CIV. CODE § 25.6 (West 1982) (no notification provision); COLO. REV. STAT. § 13-22-103 (1987) (no notification provision); GA. CODE ANN. § 31-9-2 (1985) (no notification provision); ILL. REV. STAT. ch. 111, para. 4501 (1987) (no notification provision); IND. CODE § 16-8-12-2(2)(c) (1988) (no notification provision); KY. REV. STAT. ANN. § 214.185(5) (Baldwin Supp. 1989) (Health professional may inform the minor's parent or guardian of treatment given or needed if he judges that it would benefit the minor's health); LA. REV. STAT. ANN. § 40:1299.53(c) (West 1977) (no notification provision); MD. HEALTH-GEN. CODE ANN. § 20-102 (1987) (Health professional is not required but may, even over express objection of the minor, give the minor's parent or guardian information concerning treatment needed or given, except abortion); MASS. GEN. L. ch. 112, § 12F (1988) (All information and records are confidential between minor and physician and shall not be released without the written consent of the minor or a court order. However, when the condition of minor is such that his life or limb is endangered, the physician or dentist shall notify the parents or guardian and inform the minor of the notification); Minn. Stat. § 144.346 (1988) (The professional may inform the minor's parent or guardian of treatment given or needed when failure to do so would jeopardize the minor's health); MISS. CODE ANN. § 41-41-3(c) (Supp. 1988) (No notification provisions, however § 41-41-11 empowers the married minor to waive the medical privilege); MO. REV. STAT. § 431.062(1.)(3) (1986) (Physician may, with or without the minor's consent, inform the minor's parent or guardian of care given or needed except when minor is found not to be pregnant or not afflicted with a venereal disease, or not suffering from drug or alcohol abuse); MONT. CODE ANN. § 41-1-403 (1989) (Health professional may but is not obligated to inform minor's spouse, parent or guardian of treatment given or needed when: severe complications are present or anticipated; major surgery or prolonged hospitalization is necessary; failure to inform would jeopardize the safety and health of the minor, his siblings, or the public; informing would benefit the minor's physical and mental health and family harmony; or the hospital requires a third party commitment to pay for services.); NEV. REV. STAT. § 129.030(3) (1987) (Health professional shall attempt to gain minor's consent to communicate with minor's parent or legal guardian, and shall note such attempts. However if such efforts would jeopardize treatment necessary for minor's life or necessary to avoid a serious and immediate threat to the minor's health, the professional may omit such efforts and make note of the reasons); N.M. STAT. ANN. § 24-10-1 (1987) (no notification provision); N. Y. PUBLIC HEALTH LAW § 2504 (McKinney 1984) (no notification provision); OKLA. STAT. tit. 63, § 2602(B) (1981) (Health professional may but is not required to inform spouse, parent or guardian of treatment given or needed. However, information shall not be disclosed to any health professional, school, law

enforcement agency or official, court authority, government agency or official employer, without the consent of the minor or court order unless necessary to the health of the minor and the public); PA. STAT. ANN. tit. 35, § 10101 (Purdon 1977) (no notification provision); R.I. GEN. LAWS § 23-4.6-1 (1989) (no notification provision); S.C. CODE ANN. § 20-7-270 (Law. Co-op. 1985) (no notification provision); VA. CODE ANN. § 54.1-2969(E) (1988) (no notification provision); WYO. STAT. § 14-1-101 (1986 & Supp. 1989) (no notification provision).

136. ALA. CODE § 22-8-5 (1984) (no notification provision); ALASKA STAT. § 09.65.100(3) (1983) (no notification provision); ARK. CODE ANN. § 20-9-602(2) (1987) (no notification provision); COLO. REV. STAT. § 13-22-103(3) (1987) (no notification provision); CONN. GEN. STAT. § 19a-285 (1987) (no notification provision); DEL. CODE ANN. tit. 13, § 707(a)(4) (1981) (no notification provision); FLA. STAT. § 743.065(2) (1987) (no notification provision); GA. CODE ANN. § 31-9-2(2) (1985) (no notification provision); IDAHO CODE § 39-4303 (1985) (no notification provision); ILL. REV. STAT. ch. 111, para 4502 (1987) (no notification provision); KAN. STAT. ANN. § 38-122 (1986) (no notification provision); KY. REV. STAT. ANN. § 214.185(6) (Baldwin Supp. 1989) (professional may inform the parent or guardian when he judges it would benefit the minor's health); LA. REV. STAT. ANN. § 40:1299.53(b) (West 1977) (no notification provision); MD. HEALTH-GEN. CODE ANN. § 20-102(e) (1982) (health professional is not required but may, without the consent of or over the express objection of a minor, disclose information to the minor's parent or guardian about treatment given or needed, except abortion); MINN. STAT. § 144.346 (1988) (professional may inform the minor's parent or guardian of treatment given or needed when failure to do so would jeopardize the minor's health); MISS. CODE ANN. § 41-41-3(b) (Supp. 1988) (no notification provision); MO. REV. STAT. § 431.062(3) (1986) (physician may, with or without the minor's consent, disclose information to the minor's parents about care given or needed if the physician has reason to know the whereabouts of the parent); MONT. CODE § 41-1-403 (1989) (health professional may but is not obligated to inform minor's spouse, parent or guardian of treatment given or needed when: severe complications are present or anticipated; major surgery or prolonged hospitalization is necessary; failure to inform would jeopardize the safety and health of the minor, his siblings, or the public; informing would benefit the minor's physical and mental health and family harmony; or the hospital requires a third party commitment to pay for services); N.J. STAT. ANN. § 9:17A-5 (West 1976) (physician is not required but may inform the minor's spouse parent or guardian of treatment needed or given, even over the minor's express objection); OKLA. STAT. tit. 63 § 2602 (1981) (notification of the minor's spouse, parent or guardian is within the discretion of the health professional. Disclosure to any health professional, school, law enforcement agency or official, court authority, government agency or official employer requires the minor's consent unless necessary

for the health of the minor and public); MASS. GEN. L. ch. 112, § 12F (1988) (information and records shall be confidential between minor and physician and not released without written consent of minor or judicial order. However, if the condition of the minor is so serious that his life or limb is endangered, the physician or dentist shall notify the parents or guardian and inform the minor of the notification); NEV. REV. STAT. § 129.030(3) (1987) (health professional shall attempt to gain minor's consent to communicate with minor's parent or legal guardian, and shall note such attempts. However if such efforts would jeopardize treatment necessary for minor's life or necessary to avoid a serious and immediate threat to the minor's health, the professional may omit such efforts and make note of the reasons); N.Y. PUB. HEALTH LAW § 2504(2) (McKinney 1985) (no notification provision); PA. STAT. ANN. tit. 35, § 10102 (Purdon 1977) (no notification provision); R.I. GEN. LAWS § 23-4.6-1 (1989) (no notification provision); S.C. CODE ANN. §§ 20-7-300, 20-7-270 (Law. Co-op. 1985) (no notification provision); UTAH CODE ANN. § 78-14-5(4)(a) (1987) (no notification provision).

137. ALASKA STAT. § 09.65.100(1) (1983) (no notification provision); CAL. CIV. CODE § 34.6 (West 1982) (health professionals may, with or without the minor's consent disclose to the minor's parent or guardian information about the treatment given or needed if physician has reason to know the whereabouts of the parents or guardians); COLO. REV. STAT. § 13-22-103 (1987) (no notification provision); IND. CODE § 16-8-12-2(2)(B) (1988) (no notification provision); MASS. GEN. L. CH. 112, § 12F (1988) (all information and records shall be confidential between minor and physician and not released without written consent of minor or judicial order, but if the condition of the minor is so serious that his life or limb is endangered, the physician or dentist shall notify the parents or guardian and inform the minor of the notification); MINN. STAT. § 144.346 (1988) (professional may inform the minor's parent or guardian of treatment given or needed when failure to do so would jeopardize the minor's health); MONT. CODE § 41-1-403 (1989) (health professional may but is not obligated to inform minor's spouse, parent or guardian of treatment given or needed when: severe complications are present or anticipated; major surgery or prolonged hospitalization is necessary; failure to inform would jeopardize the safety and health of the minor, his siblings, or the public; informing would benefit the minor's physical and mental health and family harmony; or the hospital requires a third party commitment to pay for services); NEV. REV. STAT. § 129.030(3) (1987) (health professional shall attempt to gain minor's consent to communicate with minor's parent or legal guardian, and shall note such attempts. However if such efforts would jeopardize treatment necessary for minor's life or necessary to avoid a serious and immediate threat to the minor's health, the professional may omit such efforts and make note of the reasons); OKLA. STAT. TIT. 63, § 2602(B) (1981) (health professional may but is not required to

inform spouse, parent or guardian of treatment given or needed, but information shall not be disclosed to any health professional, school, law enforcement agency or official, court authority, government agency or official employer, without the consent of the minor or court order unless necessary to the health of the minor and the public); TEX. FAM. CODE § 35.03(d) (1986 & Supp. 1989) (physician may inform the minor's parent or guardian of treatment needed or given with or without the minor's consent); WYO. STAT. § 14-1-101(b)(iv) (1986 & Supp. 1989) (no notification provision).

138. CAL. CIV. CODE § 25.7 (West 1982) (no notification provision); IND. CODE § 16-8-12-2(2)(D) (1988) (no notification provision); MASS. GEN. L. ch. 112, § 12F(iii) (1988) (all information and records are confidential between the minor and physician or dentist, and shall not be released without the minor's written consent or a judicial order, but when the minor's condition is such that his life or limb is endangered, the physician shall notify the minor's parent and inform the minor of the notification); TEX. FAM. CODE § 35.03 (Vernon 1986 & Supp. 1989) (physician may inform the minor's parent or guardian of treatment needed or given with or without the minor's consent); WYO. STAT. § 14-1-101(ii) (1986 & Supp. 1989) (no notification provision).

139. ALA. CODE § 22-8-4 (1984) (no notification provision); MONT. CODE § 41-1-403 (1989) (health professional may but is not obligated to inform minor's spouse, parent or guardian of treatment given or needed when: severe complications are present or anticipated; major surgery or prolonged hospitalization is necessary; failure to inform would jeopardize the safety and health of the minor, his siblings, or the public; informing would benefit the minor's physical and mental health and family harmony; or the hospital requires a third party commitment to pay for services.); PA. STAT. ANN. tit. 35, § 10101 (Purdon 1977) (no notification provision).

140. ARK. CODE ANN. § 20-9-602(7) (1987) (no notification provision); IDAHO CODE § 39-4302 (1985) (no notification provision); MISS. CODE ANN. § 41-41-3(h) (Supp. 1988) (no notification provision); NEV. REV. STAT. § 129.030(3) (1987) (Health professional shall attempt to gain minor's consent to communicate with minor's parent or legal guardian, and shall note such attempts. However if such efforts would jeopardize treatment necessary for minor's life or necessary to avoid a serious and immediate threat to the minor's health, the professional may omit such efforts and make note of the reasons; N.H. REV. STAT. ANN. § 318-B:12a (1984) (no notification provision).

141. Hofman, A.D., Children's Hospital of Orange County, Orange, CA., personal communication, August 1989. Schonberg, S.K., Montefiore Hospital, Bronx, N.Y., personal communication, July 1989.

142. See, e.g., Brief for Petitioners at 16-23 Hodgson v. Minnesota, 853 F.2d 1452 (8th Cir. 1988) (en banc), appeal filed (U.S. Feb. 3, 1989) (No. 88-11257), 110 S.Ct. 400 (1989).

143. See Appendix B for a discussion of existing ethical standards related to the delivery of health services to adolescents.

144. Hofman, A.D., Children's Hospital of Orange County, Orange, CA, personal communication, August 1989.

145. The following studies deal with the impact of parental notification upon utilization of family planning and abortion services: Blum R.W. and Resnick, M., "Adolescent Sexual Decision-Making: Contraception, Pregnancy, Abortion, Motherhood," Ped. Annals 11(10):797-805, October 1982; Blum, R.W., Resnick, M. and Stark, T., "The Impact of Parental Notification Law on Adolescent Abortion Decision-Making," Am. J. of Pub. Health 77(5):619-620, May 1987; Cartoof V.G. and Klerman, L.V., "Parental Consent for Abortion: Impact of the Massachusetts Law," Am. J. of Public Health 76(4):397-400, April 1986; Chamie, M., Eisman, S., Forrest, J.D., et al., "Factors Affecting Adolescents' Use of Family Planning Clinics," Family Planning Perspectives 14(3):126-139, May/June 1982; Clary, F., "Minor Women Obtaining Abortions: A Study of Parental Notification in a Metropolitan Area" Am. J. of Public Health 72(3):283-285, March 1982; Torres, A., "Does Your Mother Know ...?," Family Planning Perspectives 10(5):280-282, September/October 1978; Torres, A., Forrest, J.D. and Eisman, S., "Telling Parents: Clinic Policies and Adolescents' Use of Family Planning and Abortion Services," Family Planning Perspectives 12(6):284-292, November/December 1980; Zabin L.S. and Clark, S.D., "Institutional Factors Affecting Teenagers' Choice and Reasons for Delay in Attending a Family Planning Clinic" Family Planning Perspectives 15(1):25-29, January/February 1983; Zabin L.S. and Clark, S.D., "Why They Delay: A Study of Teenage Family Planning Clinic Patients" Family Planning Perspectives 13(5):205-216, September/October 1981.

146. See text, infra at 5-6 and accompanying notes.

PART TWO
MINORS' COMPETENCY TO MAKE HEALTH CARE DECISIONS

NOTES

1. See text *supra* at 3-4.

2. See text *supra* at 4.

3. See text *supra* at 4.

4. See text *supra* at 9-23.

5. See, e.g., Melton, G., "Children's Consent: A Problem in Law and Social Science," *Children's Competence to Consent*, G. Melton, G. Koocher, and M. Saks (eds.) (New York, N.Y.: Plenum Press, 1983).

6. Wald, M., "Children's Rights: A Framework for Analysis," *U.C. Davis Law Rev.* 12:255-282, 1979.

7. See text *supra* at 4 and accompanying notes.

8. Keeton, W.P., *supra* n. 8 at 190-92. For development of the informed consent doctrine see Appelbaum, P.S., Lidz, C.W. and Meisel, A., *Informed Consent: Legal Theory and Clinical Practice* (New York, N.Y.: Oxford University Press, 1987), 24-27; for state by state analysis of the application of the informed consent doctrine, see Rosoff, A.J., *Informed Consent: A Guide for Health Care Providers*, (Rockville, MD: Aspen Systems Corp., 1981).

9. American Law Institute, *Restatement of the Law (Second) of Torts*, § 892B[3] (St. Paul, Minn.: American Law Institute Publishers 1979).

10. App[illegible]aum, P.S., Lidz C.W., and Meisel, A., *supra* n. 8 at 60-62.

11. Mnookin, R.H. *Child, Family and State, Problems and Materials on Children and the Law* (Boston, Mass.: Little, Brown, 1978), p. 343.

12. *Id*. Note, "Restructuring Informed Consent: Legal Therapy for the Doctor-Patient Relationship," *Yale L.J.* 79:1533-1576, 1970.

13. Lidz, C.W., Meisel, A., Zerubavel, E., et al., *Informed Consent: A Study of Decisionmaking in Psychiatry* (New York, N.Y.: The Guilford Press, 1984), p. 4.

14. See text *supra* 4 and accompanying notes.

15. Id.

16. See text supra 1-12 - 1-13 and accompanying notes.

17. See, e.g., Melton, G.B., "Legal Regulation of Abortion, Unintended Effects," American Psychologist 42:79-83 January 1987.

18. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Making Health Care Decisions, Vol. 1: Report, (Washington, D.C.: The Commission 1982). See also, Roth, L.H., Meisel A., and Lidz, C.W., "Tests of Competence to Consent to Treatment," Am. J. Psychiatry 135:279-284, March 1977. (The various legal, medical and psychiatric tests of competency being utilized may be categorized as: evidencing a choice, "reasonable" outcome of choice, choice based on "rational" reasons, the ability to understand and actual understanding).

19. See, e.g., Weithorn L.A., and Campbell, S.B., "The Competency of Children and Adolescents to Make Informed Treatment Decisions," Child Development 53:1589-98, 1982 (hereafter cited as Weithorn & Campbell [1982]).

20. The findings of the core studies and the central issue of age are discussed in text infra, at 55-60. These core studies are summarized in Appendix A.

21. In the interest of preserving the clarity of methodological language, these will be called "comparison" groups and not "control" groups. Control groups exist only in experimental designs, where random assignment is both possible and essential-otherwise one has something other than an experiment. In developmental research, subjects cannot be randomly assigned to age groups, and therefore the studies are not true experiments and the groups being compared are not control groups. They are, however, directly analogous to control groups.

22. The findings of the supplemental studies and the effects of other variables are discussed, in text infra at 60-63.

23. Such "standards" as the courts have articulated give general guidance to a judge in determining whether a patient who might otherwise be regarded as incompetent may be found competent to consent to or refuse treatment. For examples: the patient's capacity or ability to understand the information being given in informed consent procedures, the patient's capacity to appreciate the significance of the information give, the ability to rationally manipulate information in decision-making about a problem situation. By contrast, in the area of the waiver of constitutional rights by juveniles, one commentator was able to distill the following "standards" from court decisions: (a) comprehension of rights, (b) beliefs about the legal context (how the rights function in the context in which the juvenile is

asserting or waiving them, and (c) possibly the ability to "weigh" the information or "consider" certain consequences. Grisso, T., Juveniles' Waiver of Rights: Legal and Psychological Competence (New York, N.Y.: Plenum Press, 1981), However, these standards do point to competence as a cognitive ability and they emphasize the particular relevant content areas. But they remain, on the other hand, vague standards. See, discussions of these issues in Roth, L.H., Meisel, A., and Lidz, C.W., supra note 18, Weithorn & Campbell [1982], supra note 19, Grisso, T., Evaluating Competencies: Forensic Assessments and Instruments (New York, N.Y.: Plenum Press, 1986), ch. 10.

24. Obviously, if the law provided a more operational standard of what it meant by adequate competence, the adult comparison groups would be unnecessary. The most desirable strategy would be to compare the actual performance of samples of adolescents against the legally prescribed standard, what has been described above as the second possible research strategy.

25. The strategy is ingenious in that it makes use of the law's meaning of competence even when the law does not know what it means by that concept.

26. As we shall see, this problem appears not to be a problem because in most of the studies the adolescents met even this inappropriately high standard.

27. Numerous studies show that some aspects of cognitive and intellectual functioning improve (notably "crystallized intelligence abilities," such as verbal comprehension, general information and experiential evaluation), while others decline, some of them quite sharply, from their peak at around age 25-30. These declining abilities include "fluid intelligence abilities" (such as inductive reasoning, figural reasoning, unspeeded reasoning, and intelligence measured by the Wechsler test) and most memory abilities. Horn, J.L. and Donaldson, G., "Cognitive Development in Adulthood," Constancy and Change in Human Development, O.G. Brim and J. Kaplan (eds.) (Cambridge, Mass: Harvard University Press, 1980). The apparent superiority of adult intellect is due to the salience of their crystallized intelligence, and the fact that adults usually are called upon to perform in their areas of expertise, where their crystallized intelligence will shine. Realize that health care decision-making in the face of serious health problems is a novel experience for most adults as well as minors. It is entirely possible, and perhaps likely, that the minors would recall necessary information and process that information better than persons several decades older.

28. Statistical power is defined as "the probability of rejecting the null hypothesis when the null hypothesis is false. . . . Put another way, power is the probability of not making a type II

error, i.e., of not overlooking an effect or a relationship that is really there." Rosenthal R. and Rosnow, R., Essentials of Behavioral Research: Methods and Data Analysis (New York, N.Y.: McGraw-Hill, 1984).

29. This is an unfortunate convention given the present context--whether to accept a null hypotheses.

30. See discussions in Byrnes, J., "Formal Operations: A Systematic Reformulation," Developmental Review 8:66-87, 1988; Gardner, W., Scherer, and Tester, M., "Asserting Scientific Authority: Cognitive Development and Adolescent Legal Rights," American Psychologist 44:895-902, 1989; T. Grisso, supra note 22; and Keating, D.P., "Thinking Processes in Adolescence," Handbook of Adolescent Psychology, J. Adelsen (ed.) (New York, N.Y.: Wiley Pub., 1980).

31. This probably is due to the fact that an enormous amount of human learning is the product of modeling, and in real world settings children and adolescents have far more opportunity to learn through observation of similarly situated others than is possible in a simulation experiment. Adults, having already had more such social contact would be less disadvantaged in the study, and therefore might seem to perform better.

32. This is analogous to a result-orientation in law, hidden behind a disingenuous asserted concern for neutral principles or fair procedures.

33. None of the core studies involved decisions that resulted in real consequences for the decision-maker.

34. Lewis, C.C., "A Comparison of Minors' and Adults' Pregnancy Decisions," Am. J. Orthopsychiatry 50(3):446-453, July 1980 (hereinafter cited as Lewis [1980].

35. Weithorn L.A., and Campbell, S.B. [1982], supra n. 19.

36. Kaser-Boyd, N., Adelman, H.S., Taylor L. and Welson, P., "Children's Understanding of Risks and Benefits of Psychotherapy," J. of Clinical Child Psychology, 15(2):165-171, 1986 (herein after cited as Kaser-Boyd et. al. [1986].)

37. Kaser-Boyd, N., Adelman, H.S., Taylor L. and Perry, N., "Minors Ability to Identify Risks and Benefits of Therapy," Prof. Psychology: Research & Prac. 16(3):411-417, 1985 (hereafter cited as Kaser-Boyd et. al. [1985]).

38. The authors note that in some of those comparisons the numbers were too small to permit a significance test to be performed, which is a serious problem.

39. Lewis, C.C., "How Adolescents Approach Decisions: Changes Over Grades Seven to Twelve and Policy Implications," *Child Development* 52:538-544, 1981 (hereinafter cited as Lewis [1981)].

40. Ambuel, B., "Developmental Change in Adolescents' Psychological and Legal Competence to Consent to Abortion: An Empirical Study and Quantitative Model of Social Policy," "Doctoral Dissertation, University of Illinois, 1989, *Dissertation Abstracts International* (in press) (hereinafter cited as Ambuel [1989]).

41. This difference is discussed in the text *infra* at 59-60.

42. Belter, R.W. and Grisso, T., "Children's Recognition of Rights Violations in Counseling," *Prof. Psychology: Research and Prac.* 15:899-910, 1984 (hereinafter cited as Belter & Grisso [1984]).

43. These included the rights: to refuse treatment, to know the reason for referral, to withhold information, to refuse to allow tape recording of the session, to confidentiality, and access to record.

44. Lewis [1980], *supra* n. 34.

45. Weithorn and Campbell [1982], *supra* n. 19.

46. Kaser-Boyd et. al. [1986], *supra* n. 36.

47. Kaser-Boyd et. al. [1985], *supra* n. 37.

48. Lewis [1981], *supra* n. 39.

49. Ambuel [1989], *supra* n. 40.

50. Belter & Grisso [1984], *supra* n. 42.

51. Lewis, C.E., Lewis, M.A., Lorimer A. and Palmer, B., "Child-initiated Care: The Use of School Nursing Services by Children in an 'Adult-Free' System," *Pediatrics* 60:499-507, 1977 (hereinafter cited as Lewis et. al. [1977]).

52. Lewis, C.E., Lewis M.A. and Ifekwunigue, M., "Informed Consent by Children and Participation in an Influenza Vaccine Trial," *Am. J. Pub. Health* 68(11):1079-1082, November 1978 (hereinafter cit as Lewis et. al. [1978]).

53. Kazdin, A.E., "Acceptability of Psychotherapy and Hospitalization for Disturbed Children: Parent and Child Perspectives," *J. Clinical Child Psychology* 15:330-340, 1986.

54. See Melton, G.B., "Children's Participation in Treatment Planning: Psychological and Legal Issues," *Professional Psychology* 12(2):246-252, April 1981; Dollinger, S.J. and Thelen, M.H.,

"Children's Perceptions of Psychology," Professional Psychology 9:117-126, February 1978; Neuhauser, C., Amsterdam, B., Hines, P. and Steward, M., "Children's Concepts of Healing: Cognitive Development and Locus of Control Factors," American J. of Orthopsychiatry 48(2):335-341, April 1978; Campbell, J.D., "Illness is a Point of View: The Development of Children's Concepts of Illness," Child Development 46(1):92-100, 1975; Simeonsson, R., Buckley, L. and Monson, L., "Conceptions of Illness Causality in Hospitalized Children," Jl. of Pediatric Psychology 4(1):77-84, 1979.

55. Grisso, T., supra note 23.

56. The U.S. Supreme Court has found juveniles to be competent to make their own decisions in this context, and held such waiver of constitutional rights by minors to be valid. Fare v. Michael C., 442 U.S. 707 (1979).

57. This is the standard warning given to apprise criminal suspects of their constitutional rights in regard to custodial interrogation by police: the right not to answer any questions and the right to the advice and assistance of an attorney.

58. A caution is in order about a methodological difference is in order between Grisso's research and the others being reviewed here. Grisso distilled from relevant legal opinions an absolute operational standard of understanding or failure to understand Miranda warnings and their implications. By this test, at least one fourth of adults also were judged incompetent. Thus, by a direct comparison of adults and juveniles, juveniles as young as fourteen may not be seen to be significantly less competent than adults.

59. The latter two correlate with lower IQ scores, which alone may account for the decreased proportion of competent youths.

60. Lack of adequate understanding often stemmed from a failure to understand the words in the warning and the roles referred to. Some juveniles who did not understand a "right to remain silent" would understand a right "not to talk." And many failed to understand the role of defense lawyers and the nature of the attorney-client relationship--conceptualizing all adults as the enemy, and therefore thinking a right to talk with a lawyer was seen as no improvement over talking to the police.

61. Weithorn & Campbell [1982], supra n. 19.

62. Lewis et al. [1977], supra n. 51.

63. Lewis et. al. [1978], supra n. 52.

64. Lewis et. al. [1977], supra n. 51.

65. Kaser-Boyd et. al. [1986], supra n. 36.

66. Lewis et. al. [1977], supra n. 51.

67. Kaser-Boyd et al. [1986], supra n. 36.

68. Id.

69. Kaser-Boyd et al. [1985], supra n. 37.

70. Kaser-Boyd et al. (1986), supra n. 36.

71. Weithorn and Campbell [1982], supra n. 19.

72. Lewis [1981], supra n. 40.

73. See discussion in Koocher, G., "Children Under Law: The Paradigm of Consent," Reforming the Law: Impact of Child Development Research, G. Melton (ed.) (New York, N.Y.: Guilford Press, 1987.

74. See Costanzo P. and Shaw, M., "Conformity as a Function of Age Level," Child Dev. 37:967-975, 1966; Bishop B. and Beckman, L., "Developmental Conformity," Developmental Psychology 5(3):536, 1971.

75. Scherer D.G. and Reppucci, N.D., "Adolescents' Capacities to Provide Voluntary Informed Consent," L. & Hum. Behav. 12(2):123-141, 1988.

76. Would spouses yield similarly (or more or less) to comparable pressure from another spouse? Would older persons yield to pressure from adult children? We do not know. If we did know, we then could ponder whether such yielding to influence by significant persons in one's life is desirable or undesirable, and whether it is greater (or equal or lesser) prominence among adolescents qualifies them (or disqualifies them) to make their own health care decisions.

77. The distinction was first made by Deutsch, M., and Gerard, H.R., "A Study of Normative and Informational Social Influences Upon Individual Judgment," J. Abnormal and Social Psychology 51:629-636, 1955.

78. Stone, G.C., "Patient Compliance and the Role of the Expert," Journal of Social Issues 35(1):34-59, 1979; DiMatteo, M.R. and DiNicola, D.D., Achieving Patient Compliance: The Psychology of the Medical Practitioner's Role (New York, N.Y.: Pergamon Press, 1982).

79. One illustration that has been examined is consent to donate organs or tissue. It has been observed that some transplant units, inadvertently or deliberately, effectively employ such social influence techniques as successive approximations to the target behavior, compliance through induced action-taking, selective information, post-decisional dissonance reduction, expert power, unanimity of conformity pressure, modeling, social comparison processes, demand characteristics of the situation, and others. See Fellner, C.H. and Marshall, J.R., "Kidney Donors," Altruism and Helping Behavior, J. Macaulay and L. Berkowitz (eds.) (New York, N.Y.: Academic Press, 1979); Saks, M.J., "Social Psychological Contributions to a Legislative Subcommittee on Organ and Tissue Transplants," American Psychologist 33(7):680-690, 1978; Schwartz S.H., "Elicitation of Moral Obligation and Self-Sacrificing Behavior: An Experimental Study of Volunteering to be a Bone Marrow Donor," Jl. Personality and Soc. Psy. 15:283-294, 1970.

80. Perhaps the best known and most dramatic example is the "obedience" research of Stanley Milgram, in which all sorts of ordinary people were placed in a non-coercive situation where a sizable majority of them inflicted painful, and apparently lethal, electric shocks on an innocent victim. Milgram, 1965. In the health care context, some physicians say that they can get virtually any patient to consent to virtually any treatment. See Reference Note 3 in Saks, supra note 79.

81. DiMatteo, M.R. and DiNicola, D.D., supra n. 78; Haynes, R.B., Taylor D.W. and Sackett, D.L. (eds.) Compliance in Health Care (Baltimore, MD: Johns Hopkins University Press, 1979); Rodin, J. and Janis, I.L., "The Social Influence of Physicians and Other Health Care Practitioners as Agents of Change," Interpersonal Issues in Health Care H.S. Friedman and M.R. DiMatteo (eds.) (New York, N.Y.: Academic Press, 1982).

82. Belter & Grisso [1984], supra n. 42.

83. Weinstein, M., "Preparation of Children for Psychotherapy Through Videotaped Modeling," J. Clinical Child Psychology 17:131-136, 1988.

84. Hammes M., and Petersen, D., Teaching Decision-Making Skills to a Sixth Grade Population," J. of Drug Educ. 16(3):233-242, 1986.

85. Of course, the usual finding has been precisely the reverse.

86. See Keating, supra note 31; Inhelder B. and Piaget, J., The Growth of Logical Thinking from Childhood to Adolescence (New York, N.Y.: Basic, 1958); Flavell, J., The Developmental Psychology of Jean Piaget (New York, N.Y.: Van Nostrand, 1963); Flavell, J., "An Analysis of Cognitive-Developmental Sequences," Genetic Monographs 86:279-289, 1972; Neimark, E.D. and Lewis, N., "Development of Logical Problem Solving: A One-Year Retest," Child Development

39(2):527-536, 1968; Elkind, D., "Conceptual Orientation Shifts in Children and Adolescents," Child Development 37(3):493-98, 1966; Melton, G.B., Koocher G.P. and Saks M.J. (eds.) Children's Competence to Consent (New York, N.Y.: Plenum Press, 1983).

87. In cognitive development research generally, different specific skills emerge at different stages for different people, and in response to different tasks. "Even slight, and what one would expect to be insignificant, modifications in task format can drastically alter the likelihood that subjects will exhibit the concept being assessed. . . . The sizable literature that has accumulated on children's attainment of Piagetian concepts shows this to be the case for every one of the concepts investigated." Kuhn, D., "Cognitive Development," Developmental Psychology: An Advanced Textbook M.H. Bornstein and M.E. Lamb (eds.) (Hillsdale, N.J.: L. Erbaum Associates, 1984). Thus, cognitive skills are multiple, not merely manifestations of a single skill, and different tasks and contexts call forth different skills, some of which have been acquired and others not.

88. See text supra at 81-82.

89. See Roth, L.H., Meisel, A., Lidz, C.W., supra note 18 which suggests that none of the usual tests of competence relied upon by the law and health professionals--evidencing a choice, reasonableness of outcome of choice, "rational" reasons, ability to understand, actual understanding--is or can ever be used consistently and that changing circumstances and considerations modify the tests that the law or clinicians apply.

90. Comment, "Speaking for a Child: The Role of Independent Counsel for Minors," Cal.L.Rev. 75:681-706, 1987. See Zimring, F., The Changing Legal World of Adolescence (New York, N.Y.: The Free Press, 1982.

91. See President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, supra note 17 at 72-73.

92. See text supra at 5-6 and accompanying notes.

93. See text supra at 7-23 and accompanying notes.

CONCLUSION

A FRAMEWORK FOR PUBLIC POLICY FORMULATION

NOTES

1. At the present time federally funded substance abuse programs appear to be the only federally-funded programs providing or financing health services for adolescents with authorizing statutes and/or regulations issued pursuant to these statutes that deal directly with parental involvement in health care decision-making for and by adolescents. See text supra at 30 and accompanying note.

2. See Bennett, R., "Allocation of Child Medical Care Decision-Making Authority: S Suggested Interest Analysis," Va. L. Rev. 62:285-330, 1976; Ewald, L.S. "Medical Decision-Making for Children: An Analysis of Competing Interests," St. Louis U. L.J. 25:689-733, 1982; Wald, M.S. "Children's Rights: A Framework for Analysis," U.S. Davis L. Rev. 12:255-282, 1979; Harvard Law Review, "Developments in the Law--The Constitution and the Family," Harv. L. Rev. 93:1156-1383, 1980; Zimring, F.E., The Changing Legal World of Adolescence (New York, N.Y.: The Free Press/Macmillan, 1982).

3. See text infra at 34 and accompanying notes.

4. See text infra at 40 and accompanying notes.

5. See text infra at 74 and accompanying notes.

6. See text infra at 75 and accompanying notes.

7. See Appendix B for a discussion of relevant ethical standards of health professionals.

8. Various studies indicate that there are direct societal costs associated with teenage childbearing because substantial public funds are expended on the provision of services to unmarried teenagers who become mothers and their children by public programs such as the Title XIX Medical Assistance (Medicaid) Program, the AID to Families with Dependent Children (AFDC) Program and the Food Stamp Program. For example, it has been estimated that in 1985 "public costs for AFDC, Medicaid, and Food Stamps attributable to families begun when parents were teens was $16.65 billion." U.S. Congressional Research Services, Teenage Pregnancy: Issues And Legislation (Washington, D.C., April 1988).

There may also be substantial indirect societal costs associated with teenage child bearing, depending on whether and to what degree there are negative health, economic, educational, and social consequences for unmarried teenage mothers and their children over the short term and long term associated with teenage childbearing. There are studies that support the conclusion that there are such negative consequences, but there are also studies to the contrary. Compare, e.g., Zabin, L.S., Hirsch, M.B., "When Urban Adolescents Choose Abortion: Effects on Education, Psychological Status and Subsequent Pregnancy," Family Planning Perspectives 21(6):248-255, November/December 1989, with Furstenberg, F.F., Brooks-Gunn, J. and Morgan, S.P., "Adolescent Mothers and their Children in Later Life," Family Planning Perspectives 19(142):142-151, July/August 1987. See discussion in U.S. Congress, Congressional Research Services, supra at p. 7; Lewin, T., "Three Studies Cause Confusion on Impact of Teenage Pregnancy," New York Times, p. A10 (col. 3), March 7, 1990.

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APPENDIX A

SUMMARY OF CORE EMPIRICAL STUDIES

SUMMARY OF CORE STUDIES[1]

C.C. Lewis (1980)

Sample Characteristics, Methodology and Decision Domain

Sample Ages, n	Other Socio-Demographics	Methodology	Decision Domain
13-17 vs. 18-25 n = 42	Possibly pregnant; unmarried; diverse socio-economic statuses; urban California	Structured interviews comparing adults to minors (in situ) (no conseq)	Pregnancy: knowledge of law, source of advice, reasons for choice

Effects of Independent Variables

Age		Gender	Socio-Economic Status
No Differences	Differences Found		
Knowledge of laws; number of types of people consulted; advice expected; considerations of child-rearing ability in hypothetical advice-giving	Adults more likely to: consult professionals; consider ability to care for child; Minors more likely to: consider impact on parents; possible deformity. (Minors perceive decision as more externally determined.)	Unknown/unreported	Unknown/unreported

Ethnicity	Experience	Social Influence	Condition Severity	Intelligence
Unknown/unreported	Unknown/unreported	Unknown/unreported	Unknown/unreported	Unknown/unreported

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[1] In situ/simulation/hypothetical = whether study participants made their decisions in an actual health care setting, a simulated setting, or in response to a hypothetical situation; no conseq/conseq = whether the responses of study participants would have actual and immediate consequences for their own health care.

Weithorn & Campbell (1982)

Sample Ages, n	Other Socio-Demographics	Methodology	Decision Domain
9, 14, 18, 21 n = 96	Half male, half female; white; middle socio-economic status; younger groups; Long Island; older groups; Washington, D.C.	Structured interviews; hypothetical treatment dilemmas (hypothetical) (no conseq)	Choice of treatment alternatives for diabetes, epilepsy, enuresis, depression, risk benefits, etc.

Effects of Independent Variables

Age		Gender	Socio-Economic Status
No Differences	Differences Found		
Expression of a decision preference; choice of treatments (for diabetes, epilepsy, enuresis, or for depression among 14, 18, 21 year olds); and medical professionals agreed. Reasons for choices: no differences (except as noted). On factual understanding and appreciation, no differences (except as noted)	Younger more likely to choose inpatient treatment for depression; 9 year olds differed from other groups on treatment choices for depression. On reasons for choices, 9 year olds differed from other groups; 14 year olds differed on epilepsy. On factual understanding and appreciation, 9 year olds differed from all others	No differences	Unknown/unreported

Ethnicity	Experience	Social Influence	Condition Severity	Intelligence
Unknown/unreported	Unknown/unreported	Unknown/unreported	Unknown/unreported	Unknown/unreported

Kaser-Boyd, et al. (1986)

Sample Ages, n	Other Socio-Demographics	Methodology	Decision Domain
10-19 n = 75	Mild to severe learning & behavioral problems; mostly upper middle socio-economic status, some low to mid socio-economic status, mostly white, 14 non-white. Probably LA.	Structured interviews: risk; benefit sorting & decision vignettes (hypothet) (non conseq.)	Psychological treatment; risks, benefits, and irrelevant

Effects of Independent Variables

Age		Gender	Socio-Economic Status
No Differences	Differences Found		
On distinguishing risks, benefits, and irrelevant. On treatment decision vignettes.	None	Unknown/unreported	Unknown/unreported

Ethnicity	Experience	Social Influence	Condition Severity	Intelligence
Anglos higher on treatment decision vignettes	Therapy inexperienced higher on treatment decisions vignettes	Unknown/unreported	Not presently referred and moderate rather than severe behavioral problems higher on treatment decision vignettes.	Minors with poor reading comprehension were lower on risk:benefit sort; also higher on treatment decision vignettes.

Kaser-Boyd, et al. (1985)

Sample Ages, n	Other Socio-Demographics	Methodology	Decision Domain
10-13 vs. 14-20 n = 62	Behavioral disordered, emotionally disturbed, learning disabled; some with, without prior therapy experience, 70% middle socio-economic status, 20% low-mid, 10% low; mostly white, 16 non-white; 67% male. Probably LA.	Structured interviews: understand and assess risks and benefits (rate own and hypothetical therapy) (no conseq)	Psychological treatment; risks, benefits

Effects of Independent Variables

Age		Gender	Socio-Economic Status
No Differences	Differences Found		
On risk identification. [Author's note: Ns too small in some instances to complete chi-sq]. On benefits no differences on 8 variables.	Nonsignificant trend for younger to say did not know if risks existed. On benefits older group thought therapy helped you learn new things. Older groups used more abstract concepts in describing benefits.	Unknown/unreported	Unknown/unreported

Ethnicity	Experience	Social Influence	Condition Severity	Intelligence
Unknown/unreported	Experienced and referred groups more likely to assert no risks. Currently referred saw as benefits: someone to talk to, special privileges. Experienced minors more likely than inexperienced to see someone to talk to as a benefit.	Unknown/unreported	Unknown/unreported	Unknown/unreported

C.C. Lewis, et al. (1981)

Sample Ages, n	Other Socio-Demographics	Methodology	Decision Domain
12-19 n = 108 (grades 7-8, 10 and 12)	Middle to upper middle socio-economic status; 87% expected to attend college; San Francisco	Advice Ss would give in simulated peer counseling (simulation) (no conseq)	Cosmetic surgery, choice of custodial parent, research: on acne medication, on "mind"

Effects of Independent Variables

Age		Gender	Socio-Economic Status
No Differences	Differences Found		
On consulting with peers or parents. No differences in revisions of attitudes in light of new information.	With increasing age there is increasing probability of mentioning: risks, future consequences, independent specialist as consultant, existence of and caution against adult vested interests.	Unknown/unreported	Unknown/unreported

Ethnicity	Experience	Social Influence	Condition Severity	Intelligence
Unknown/unreported	Unknown/unreported	Unknown/unreported	Unknown/unreported	Unknown/unreported

STUDIES ON MARGINS OF CORE

C.E. Lewis, et al. (1977)

Sample Ages, n	Other Socio-Demographics	Methodology	Decision Domain
5-12 n = ??	UCLA University Elementary School. Replicated in LA public school: 38% Hispanic, 28% Black, 25% white; 38% on ADC	Systematic observation of innovative program (in situ) (conseq)	Children's own health decisions

Effects of Independent Variables

Age		Gender	Socio-Economic Status
No Differences	Differences Found		
Use patterns of health services closely resembled that of adults. (No direct test.)	Unknown/unreported	Ratio of use similar to adults: girls more use than boys	In university school, the more affluent made more visits. Better groups of the disadvantaged made more visits. Affluent saw physicians in a more minor role in health maintenance than poorer kids did.

Ethnicity	Experience	Social Influence	Condition Severity	Intelligence
White minors increasingly saw themselves as decision-makers; same shift did not occur for Black and Hispanic	Unknown/unreported	Unknown/unreported	Unknown/unreported	Unknown/unreported

C.E. Lewis, et al. (1978)

Sample Ages, n	Other Socio-Demographics	Methodology	Decision Domain
6-9 n = 213	85% white; middle to upper middle socio-economic status; west LA	Groups of minors asking non-directive Q & A to elicit information (in situ) (potential conseq)	Whether to participate in swine flu experimental trials

Effects of Independent Variables

Age		Gender	Socio-Economic Status
No Differences	Differences Found		
No differences, except for one class of 6 year olds, no differences in information elicited.	Older minors more often asked about problem of flu striking. The younger the minors, the less likely they were to give consent.	No differences in questions asked. Boys volunteered less. Girls were more unable to decide	Unknown/unreported

Ethnicity	Experience	Social Influence	Condition Severity	Intelligence
Unknown/unreported	High users of health services more likely to volunteer	Unknown/unreported	Unknown/unreported	Unknown/unreported

Problems: Lack of significance tests, lack of independence among Ss.

Scherer & Reppucci (1988)

Sample Ages, n	Other Socio-Demographics	Methodology	Decision Domain
14, 15 n = 40	Equal M & F; middle to upper middle socio-economic status; Probably Charlottesville, VA	Hypothetical treatment dilemmas (hypothet) (no conseq)	Informed consent for treatment of: tonsillitis, depression, enuresis, warts, kidney donation

Effects of Independent Variables

Age		Gender	Socio-Economic Status
No Differences	Differences Found		
No effects reported.	Unknown/unreported	No effects reported	Unknown/unreported

Ethnicity	Experience	Social Influence	Condition Severity	Intelligence
Unknown/unreported	Unknown/unreported	As parental pressure increased, Ss confidence in decision decreased. The more evasive and consequential the choice, the less susceptible the parental influence. The more socially sensitive, the greater the parental influence.	Unknown/unreported	Unknown/unreported

B. Ambuel (1989)

Sample Ages, n	Other Socio-Demographics	Methodology	Decision Domain
13-21 n=75	All women, diverse racial, economic, and religious backgrounds	Questionnaires plus factor analysis and regression modeling of semi-structured interviews	Broad range of knowledge, affect, decision conflict around unplanned pregnancy

Effects of Independent Variables

Age		Gender	Socio-Economic Status
No Differences	Differences Found		
Volitional and cognitive facets of competence for all groups except those 13-15 who did not consider abortion	Those 13-15 who did not consider abortion scored lower on most measures of cognitive competence and volitional competence	Unknown/unreported	Unknown/unreported

Ethnicity	Experience	Social Influence	Condition Severity	Intelligence
Unknown/unreported	Unknown/unreported	Unknown/unreported	Unknown/unreported	Unknown/unreported

Belter & Grisso (1984)

Sample Ages, n	Other Socio-Demographics	Methodology	Decision Domain
9, 15, 21 n=60	All males, predominantly white, middle-class, average to above average IQ	Experimentally varied whether Ss were briefed or not on patients' rights	Recognizing and protecting violations of patient rights

Effects of Independent Variables

Age		Gender	Socio-Economic Status
No Differences	Differences Found		
On rights recognition or protection between 15 and 21 year olds who were briefed	9-year-olds showed less recognition of rights violations and failed to protect own rights less than the other two groups	Unknown/unreported	Unknown/unreported

Ethnicity	Experience	Social Influence	Condition Severity	Intelligence
Unknown/unreported	Briefing on rights had no effect on 9-year olds; large and similar effect on 15 and 21 year olds	Unknown/unreported	Unknown/unreported	Unknown/unreported

APPENDIX B
MINORS' ACCESS TO HEALTH SERVICES: EXISTING ETHICAL STANDARDS

Having described the existing laws pertaining to the delivery of health services to adolescent, there remains to be described the existing ethical standards pertaining to the delivery of adolescent services. The term "ethical" for this purpose is equivalent to the term "moral",[1] and the term "standards" for this purpose may be defined as the professional norms governing the behavior of members of the professional engaged in the adolescent health service provision. Requests were made for written statements of ethical standards relevant to adolescent health care to a number of professional organizations, made up of and representing physicians, nurses, psychiatrists, psychologists and social workers, and hospital personnel.[2] "Standards," "codes," "policies," "principles," and "model acts" issued or approved were received in response to these requests.[3]

Existing ethical standards, as manifested in statements of professional organizations, revolve around the concept of confidentiality of the relationship between the provider of health services and the patient or client. A central principle of medical ethics with a long lineage is that:

> A physician may not reveal the confidences entrusted to him in the course of medical attendance . . . unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.[4]

This principle, with its stress on confidentiality but its acknowledgement that legal obligations and the welfare of the individual and the community may take precedence over confidentiality, typifies ethical principles of confidentiality to which the health professions adhere. However, few of the ethical standards issued or approved by professional organizations speak directly to the confidentiality of the relationship between a provider of health services and an adolescent, and the particular and peculiar problems of this relationship from the standpoint of confidentiality principles are simply not mentioned in most of these standards.

This situation led the American Academy of Pediatrics in 1981 to sponsor a Conference on Consent and Confidentiality in Adolescent Health Care involving as participants individuals from different disciplines. The resulting conference report articulated broad principles on which conference participants largely agreed as follows:

- With respect to adolescence, there exists an enduring need to balance delicately the relative rights and needs of minors to confidential health services with the relative rights and responsibilities of parents toward their offspring.

- Adolescent should have access to needed health services.

- Adolescents, unless fairly adjudged incompetent, should participate in decisions pertaining to their health.

- The concept of "mature minor" and the capacity of that individual to consent is recognized.

- Even when adolescents seek health care on their own consent they should be encouraged to involve their parents, unless there is compelling reason not to do so. (In that case, often an alternative adult adviser/relative is appropriate.)

- Chronologic age is not a suitable yardstick to determine an adolescent's maturity and capacity to give informed consent. Development criteria are far more telling, as applied on an individual basis.

- Adolescents generally should be entitled to confidentiality in their own health care, and that presumption should be overridden only by good reason.

- Parental notification should be encouraged but not be made mandatory in the provision of adolescent health care, especially inasmuch as the absence of guaranteed confidentiality could deter many young persons from seeking and receiving necessary services.

- Adolescents should have the same right of access to their health care records as do adults unless there is compelling reason to the contrary.

- Disclosure of health data to third parties, such as health insurers, should only be with parents' informed consent and/or that of adolescents if it pertains to care they have received on their own. As a general rule, adolescents should retain the right to consent to such disclosure with or without parental participation, and even if the adolescent did not originally consent to the health are, unless there is a compelling reason not to.

- Health providers and third-party repositories periodically should review data collected during an individual's minority to reassess its relevance, expunging data no longer needed.
- To protect adolescents they should be provided with some record as to where their health information was sent, when it was sent and for what purpose.[5]

More recently the American College of Obstetricians and Gynecologists issued a specific policy statement on confidentiality in adolescent health care, that was approved as policy not only by ACOG but also by the American Academy of Family Physicians, the American Academy of Pediatrics, NAACOG -- The Organization for Obstetric, Gynecologic and Neonatal Nurses and the National Medical Association. This policy statement which sets forth the most extensive standards thus far specifically dealing with adolescent health care provides as follows:

1. Health professionals have an ethical obligation to provide the best possible care and counseling to respond to the needs of their adolescent patients.
2. This obligation includes every reasonable effort to encourage the adolescent to involve parents, whose support can, in many circumstances, increase the potential for dealing with the adolescent's problems on a continuing basis.
3. Parents are frequently in a patient relationship with the same providers as their children or have been exercising decision-making responsibility for their children with these providers. At the time providers establish an independent relationship with adolescents as patients, the providers should make this new relationship clear to parents and adolescents with regard to the following elements:
    a. The adolescent will have an opportunity for examination and counseling apart from parents, and the same confidentiality will be preserved between the adolescent patient and the provider as between the parent/adult and the provider.

    b. The adolescent must understand under what circumstances (eg, life-threatening emergency), the provider will abrogate this confidentiality.

    c. Parents should be encouraged to work out means to facilitate communication regarding appointments, payment, or other matters consistent with the understanding reached about confidentiality and parental support in this transitional period when the adolescent is moving toward self-responsibility for health care.

4. Providers, parents, and adolescents need to be aware of the nature and effect of laws and regulations in their jurisdictions that introduce further constrains on these relationships. Some of these laws and regulations are unduly restrictive and in need of revision as a matter of public policy. Ultimately, the health risks to the adolescents are so impelling that legal barriers and deference to parental involvement should not stand in the way of needed health care.[6]

The ACOG policy statement, together with the principles enunciated by the AAP conference, which would seem to have broad based professional support, indicate that providers of health services to adolescents are in theory generally more willing than courts or legislatures have been to grant adolescent autonomy in the making of health care decision and to afford protection to the confidentiality of the relationship between the provider of health services and the adolescent. This statement and these principles do not endorse current legal requirements of parental consent and notification. Rather parental involvement is to be encouraged but it is to be permissive rather than mandatory. What little empirical research which has been done in this area also suggests that health service providers are willing to grant such autonomy and afford such protection.[7]

There remains the question of how helpful existing standards in the form of official statements by professional organizations are in resolving the kind of ethical problems that arise in providing health services to adolescents. The following fact situations, compiled by a nationally recognized expert on adolescent medicine, are illustrative of such problems:[8]

- A 16-year old boy is discovered to have a malignant tumor of bone. Appropriate treatment requires amputation of his leg. His parents consent to the surgery but he refuses. He will accept all other forms of treatment but would "rather die with both legs than survive as a cripple!" Do you operate without the consent of the boy? Do you seek a court order against the wishes of the boy?

- A 17-year old boy is admitted to the Intensive Care Unit with multiple fractures and disorientation. He was the driver of an automobile involved in a collision in which three passengers were killed. As part of the evaluation of his state of consciousness you determine that his blood alcohol level is well above the legal limits for intoxication. Do you share this information with his family in explanation for his confusion? Do you share this information with the authorities who are investigating this fatal accident?

- A 16-year old girl is brought to care by her mother who is concerned about poor school performance and disruptive behavior. In your private interview with the girl she confides that she is smoking marijuana a few nights each week. The girl feels that her current problems relate to the unrealistic expectations of her mother regarding performance and behavior. She insists that the confidentiality of her interview be respected and that the information about her drug use not be shared with her mother. Do you tell the mother anyway? What if the mother specifically asks, "Is my daughter using drugs?" The mother requests that a portion of the urine sample collected for routine analysis be sent for drug testing. Do you accede to this request?

- A 15-year old girl returns with her parents to discuss her recently diagnosed pregnancy. Her parents are certain that the only acceptable course of action is to terminate the pregnancy. The girl is adamant in her refusal to consider an abortion. What do you do?

- A 16-year old girl is brought for evaluation by her mother because of a complaint of abdominal pain. Physical examination and laboratory evaluation reveal a vaginal discharge secondary to gonorrhea. The girl admits to multiple brief intimate relationships over the past few months. She states that her mother would "kill her" if she found out. You know the family and the mother is a bit of a tyrant with a quick temper. What do you tell the mother.

- An 18-year old homosexual male presents for care requesting testing for AIDS. His affect is depressed and upon questioning he admits to frequent suicidal ideation and one prior attempt. He is certain "he would kill himself" if he finds out he has AIDS, but must know the results of his testing because not knowing is "driving him crazy." Do you do HIV testing?

- You are caring for a 17-year old intravenous drug abuser who you know to be HIV positive. For the very first time he appears to be sincerely motivated to enter into a drug abuse treatment program. He asks that you complete the required preadmission history and examination form but insists that you make no mention of his HIV status. Do you fill out and sign the form omitting reference to his HIV status?

- A recently married 19-year old with a past history of homosexual activity is found to be HIV positive. He refuses to inform his bride. He is certain she would leave him. Do you tell her?

- You are caring for a 17-year old who has AIDS secondary to a transfusion. His 16 year old girl friend is aware of the diagnosis but they continue to have unprotected intercourse. She "doesn't care;" she "loves him." Do you inform her parents?

The existing ethical standards would appear to give little concrete guidance and direction to adolescent health service providers in resolving these problems, which present actual or potential conflicts between interests of the adolescent, the parent and the State. Perhaps this is inevitable given the sui generis nature of most ethical problems. However, this is very troublesome given the complex dilemmas that the services providers often encounter in serving adolescents.

NOTES

1. See Frankena, W.K., Ethics 5-10 (Englewood Cliffs, N.J.: Prentice-Hall Inc., 1963).

2. These organizations were as follows: American Medical Association, American College of Obstetricians and Gynecologists, American Academy of Pediatrics, American Academy of Family Physicians, The National Medical Association, American Nurses Association, NAACOG -- The Organization for Obstetric, Gynecologic and Neonatal Nurses, American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Psychologic Association, National Association of Social Workers and National Association of Children's Hospital and Related Institutions. The American Society of Adolescent Medicine was also solicited for relevant standards but indicated that it had not issued or approved such standards. The American Hospital Association did not respond to inquiries.

3. The documentation received was as follows: American Academy of Child and Adolescent Psychiatry, "Adolescent Pregnancy and Abortion Policy Statement," (adopted 1975 and amended 1982); American Academy of Child and Adolescent Psychiatry, Code of Ethics (1980) (contains clarification notes) (Washington, D.C.: American Academy of Child and Adolescent Psychiatry, 1980); American College of Obstetricians and Gynecologists, "ACOG Statement of Policy -- Confidentiality In Adolescent Health Care" reprinted in American Academy of Pediatrics News, April 1989; American College of Obstetricians and Gynecologists, "Providing Effective Contraception to Minors" (Policy statement, May 1971); American Academy of Pediatrics, Committee on Youth, "A Model Act for Consent of Minors for Health Services," reprinted in Pediatrics 51(2):293-96, 1973; American Nurses' Association, Code for Nurses with Interpretive Statements (Kansas City, MO: American Nurses Association, 1985); American Medical Association, Principles of Medical Ethics (Chicago, Ill.: American Medical Association, 1971); American Psychiatric Association, Opinions of the Ethics Committee on the Principles of Medical Ethics (Washington, D.C.: American Psychiatric Association, 1986); American Psychiatric Association, The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry (1986); American Psychological Society, Ethical Principles of Psychologists, reprinted from Am. Psychologist 36(6):633-38, 1981; American Psychological Association, Committee on Professional Standards, Specialty Guidelines for the Delivery of Services by School Psychologists, reprinted from Am. Psychologist 36(6):670-81, 1981; American Psychological Association, Division of Child, Youth and Family Services, Task Force on Legal Issues," Position statement: Standards Regarding Consent for Treatment and Research Involving Children," Draft 1982; American Psychological Association, Division of Child, Youth and Family Services, Committee on the Civil Commitment of Minors, "A Model Act for the Mental Health Treatment

for Minors," undated; National Association of Children's Hospitals and Related Institutions, Inc., "The Pediatric Bill of Rights" (endorsed 1974); National Association of Social Workers, Code of Ethics--Professional Standards (Silver Springs, MD: National Association of Social Workers, 1980); National Association of Social Workers, Provisional Council on Clinical Social Work, NASW Standards for the Practice of Clinical Social Work--Professional Standards (Silver Spring, MD: National Association of Social Workers, Inc., 1989).

4. American Medical Association, supra n. 3 at § 9.

5. American Academy of Pediatrics, Conference on Consent and Confidentiality in Adolescent Health Care 3-4 R.S. Moore and A.D. Hofman (eds.) 1982.

6. ACOG Statement of Policy, supra n. 3.

7. See, e.g., Lovett J. and Wald, M.S., "Physician Attitudes toward Confidential Care" J. Pediatrics 106:517-20, 1985.

8. Schonberg, S.K., Montefiore Hospital, Bronx, N.Y., personal communication, July, 1989.